1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13145

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13139
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 5 Yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 526 Fort Avenue

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 526 Fort Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Adeline — Middle: — Last: Alkire

4. DATE OF DEATH: Month: December — Day: 1 — Year: 1958

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct 18, 1873

9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper

10b. KIND OF BUSINESS OR INDUSTRY: At home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: David Robbinett

14. MOTHER'S MAIDEN NAME: Clyrenda Twigg

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Paul L. Alkire Cumberland Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: Sudden
422.1
DUE TO (b): Arteriosclerotic C.V. disease — -
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour — a. m. p. m. — Month, Day, Year — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: Dec. 1, 1958

EXAMINER'S NAME (Type): Benedict Skitarelic MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12/3/58

22c. NAME OF CEMETERY OR CREMATORY: Mt Olive Cemetery

22d. LOCATION (City, town, or county) (State): Oldtown Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Ruth E. Silcox Cumberland Maryland

24a. REC'D BY REGISTRAR — DATE: DEC 3 '58

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13146 **CERTIFICATE OF DEATH** 13140

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 7 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND
d. STREET ADDRESS: 1 OLDTOWN ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First ROBERT — Middle PRESTON — Last ANKENEY

4. DATE OF DEATH: Month DECEMBER — Day 4, — Year 19 58.

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MARCH 13,

9. AGE (In years last birthday): 13 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: CLAUDE ANKENEY

14. MOTHER'S MAIDEN NAME: CATHERINE SHUPP

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — Address: MEMORIAL HOSPITAL - CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Palsy — INTERVAL BETWEEN ONSET AND DEATH: From Birth
351X
DUE TO
(b): Prem Birth, Small Birth Injury.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from November 28 19 58 to Dec 4, 19 58, that I last saw the deceased alive on Dec 4, 19 58, and that death occurred at 3:30 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: B. M. Schindler M.D. — ADDRESS (Street, city or town, State): 43 Greenway Cumberland Md — DATE SIGNED: 12/5/58

PHYSICIAN'S NAME (Type): DR. BLANE M. SCHINDLER

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: Dec 7- — 22c. NAME OF CEMETERY OR CREMATORY: St Pauls Cemetery — 22d. LOCATION (City, town, or county) (State): RT 40. Near Clear Spring Md

23. FUNERAL DIRECTOR'S SIGNATURE: C. E. Johnson — ADDRESS: Berkeley Springs W. Va.

24a. REC'D BY REGISTRAR DATE: DEC 9 '58 — 24b. REGISTRAR'S SIGNATURE: Curtiss S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13141

13217 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b: 7 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 16 Uhl Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
d. STREET ADDRESS: 16 Uhl Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First JOHN — Middle R. — Last ATKINSON

4. DATE OF DEATH: Month Dec. — Day 18, — Year 19 58

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Aug. 15, 1864

9. AGE (In years last birthday): 94 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Paymaster, Ret

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (State or foreign country): Canada

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Hugh Atkinson

14. MOTHER'S MAIDEN NAME: Elizabeth Wallace

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Virgil E. Atkinson — Address: Frostburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Failure - left side — INTERVAL BETWEEN ONSET AND DEATH: 1 day -
DUE TO (b): Chronic Cardiovascular disease — Years
DUE TO (c): Arteriosclerosis — Years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 50, to Dec 18, 58, that I last saw the deceased alive on Dec 18, 58, and that death occurred at 4:40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John B. Davis, M.D. — ADDRESS (Street, city or town, state): 2 Broadway, — DATE SIGNED: 12/19/58

PHYSICIAN'S NAME (Type): John B. Davis, MD — Frostburg, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Byrial

22b. DATE THEREOF: Dec. 21, 1958

22c. NAME OF CEMETERY OR CREMATORY: Hill Crest Cemetery

22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Byron Kight — ADDRESS: Cumberland, Md.

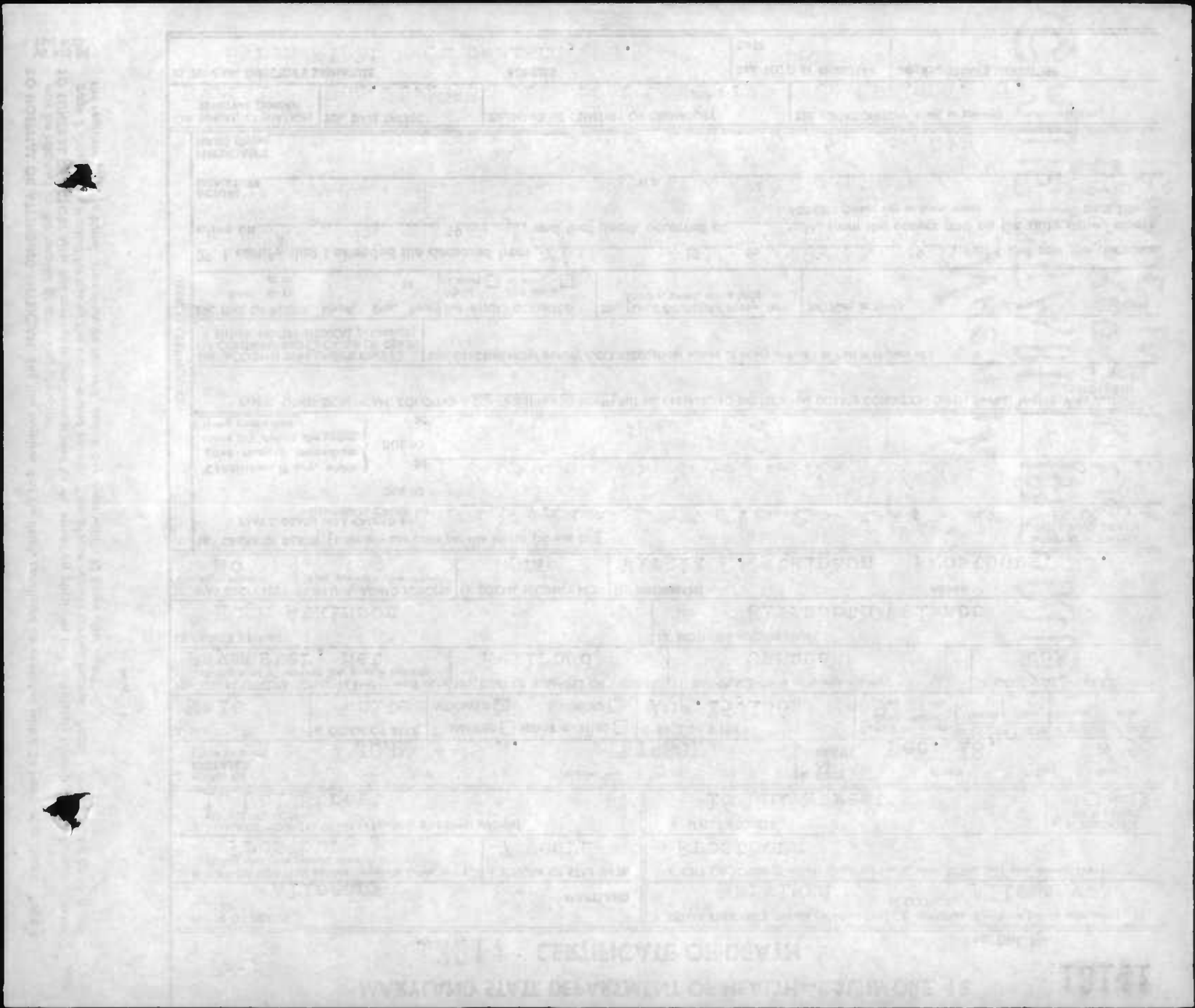
24a. REC'D BY REGISTRAR DATE: DEC 23 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13226 **CERTIFICATE OF DEATH** 13142

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Midland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Midland
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lola — Middle: B. — Last: Baker

4. DATE OF DEATH: Month: December — Day: 11 — Year: 19 58

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: November 22, 1907

9. AGE (In years last birthday): 51 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Barton, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward Clark

14. MOTHER'S MAIDEN NAME: Molly Snyder

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Thomas Baker — Address: Midland, Md.
"Husband"

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic carcinoma of liver and abdominal cavity
154X
DUE TO
(b): adenocarcinoma of rectum.
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Existed before February 1958.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from February 17 19 58 to December 11 1958, that I last saw the deceased alive on November 25, 19 58, and that death occurred at 9:25 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D.
ADDRESS (Street, city or town, state): 115 S. Centre Street
DATE SIGNED:

PHYSICIAN'S NAME (Type): Dr. A. J. Mirkin
Cumberland, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12/15/58

22c. NAME OF CEMETERY OR CREMATORY: Laurel Hill Cemetery

22d. LOCATION (City, town, or county) (State): Moscow, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: George Eichhorn
ADDRESS: Lonaconing, Md.

24a. REC'D BY REGISTRAR
DATE: DEC 15 '58

24b. REGISTRAR'S SIGNATURE: Caroline L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 FilmG237 12-29-58 et

13218 CERTIFICATE OF DEATH

13143 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westernport, Md.
c. LENGTH OF STAY IN 1b: 3 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kooken Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Westernport Cumberland
d. STREET ADDRESS: Corner 3rd and Arch Sts Walnut St.
DID RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First John — Middle E. — Last Beach

4. DATE OF DEATH: Month Dec. — Day 16 — Year 19 58

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 10, 1880

9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer Retired

10b. KIND OF BUSINESS OR INDUSTRY: Tinplate Mill

11. BIRTHPLACE (State or foreign country): Fairfax County, Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Worden Beach

14. MOTHER'S MAIDEN NAME: Sarah unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT Address: Mr. Lloyd Scheurling, Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 442x Cardio Ren_l Disease — INTERVAL BETWEEN ONSET AND DEATH: 2yrs
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO: Generalized Arteriosclerosis — 5yrs
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct Io, 19 58, to Dec I6, 19 58 that I last saw the deceased alive on Dec I5, 19 58, and that death occurred at 2.30 am, from the causes and on the date stated above.

ACTUAL SIGNATURE: James H. Wolverton Sr M.D. — ADDRESS (Street, city or town, state): 2o Green St Piedmont W Va — DATE SIGNED

PHYSICIAN'S NAME (Type): James H. Wolverton Sr Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12-18-58

22c. NAME OF CEMETERY OR CREMATORY: Davis Memorial

22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: James F. Scarpelli, Cumberland, Md.
James F. Scarpelli

24a. REC'D BY REGISTRAR DATE: DEC 22 '58

24b. REGISTRAR'S SIGNATURE: Carlton L. Kisner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13147

CERTIFICATE OF DEATH

13144

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 5 HOURS
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION): MEMORIAL HOSPITAL WARWICK & MEMORIAL AVENUES

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND
d. STREET ADDRESS: 1 15 PROSPECT SQUARE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: BABY — Middle: GIRL — Last: BOLYARD

4. DATE OF DEATH: Month: DECEMBER — Day: 28 — Year: 1958.

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: DECEMBER 28, 1958

9. AGE (In years last birthday) yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours: 5 / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): CUMBERLAND, MD.

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: RICHARD E. BOLYARD

14. MOTHER'S MAIDEN NAME: HELEN S. SINCLAIR

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No, (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: MEMORIAL HOSPITAL - CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Prematurity

DUE TO (b): Central Placenta Previa

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Hypofibrinogenemia

761.5

INTERVAL BETWEEN ONSET AND DEATH: 5 hrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec. 28, 1958 to Dec. 28, 1958, that I last saw the deceased alive on Dec. 28, 1958, and that death occurred at 8:13 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W. R. Hodges M.D. — ADDRESS (Street, city or town, state): Cumberland, Md. — DATE SIGNED: 12/28/58

PHYSICIAN'S NAME (Type): DR. W. R. HODGES

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12/31/58

22c. NAME OF CEMETERY OR CREMATORY: Blumont Cemetery

22d. LOCATION (City, town, or county) (State): Grafton, W. Va.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Charles L. George Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: DEC 30 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

2060432XVI

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13145

13146 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 30 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL WARWICK AND MEMORIAL AVES

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND
d. STREET ADDRESS: 1 610 N. MECHANIC STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOSEPH — Middle B — Last BOYD

4. DATE OF DEATH: Month DECEMBER — Day 31 — Year 1958

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: AUGUST 18 1894

9. AGE (In years last birthday): 64 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Painter

10b. KIND OF BUSINESS OR INDUSTRY: Textile Ind.

11. BIRTHPLACE (State or foreign country): MARYLAND -HANCOCK

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: WALTER BOYD

14. MOTHER'S MAIDEN NAME: HATTIE COOFFMAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes
If yes, give war or dates of service: War I

16. SOCIAL SECURITY NO.: 214-07-3802

17. INFORMANT: MEMORIAL HOSPITAL — Address: CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic Carcinoma
199.2
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12/1, 1958, to 12/31, 1958, that I last saw the deceased alive on 12/31, 1958, and that death occurred at 2:35 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Leo H. Ley Jr. M.D.
ADDRESS (Street, city or town, state): 456 N. Centre St
DATE SIGNED: 1/3/59

PHYSICIAN'S NAME (Type): LEO H. LEY JR. Cumberland Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1-3-59
22c. NAME OF CEMETERY OR CREMATORY: Greenmount Cemetery
22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: James F. Scarpelli, Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: JAN 5 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kimmis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18 Film 236 12-19-58 ams

13149

CERTIFICATE OF DEATH

13146

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 18 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WARWICK AND MEMORIAL HOSPITAL-MEMORIAL AVE.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND 02
d. STREET ADDRESS: 304 PENNSYLVANIA AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: LESTER Middle: Bryan Last: BURDETT

4. DATE OF DEATH: Month: DECEMBER Day: 11 Year: 1958

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JULY 21, 1896

9. AGE (In years last birthday): 62 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Blacksmith helper

10b. KIND OF BUSINESS OR INDUSTRY: XX B. & O. Rwy.

11. BIRTHPLACE (State or foreign country): MELROSE PARK, ILL.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: THOMAS BURDETT

14. MOTHER'S MAIDEN NAME: ISABELLE CRAWFORD

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: MEMORIAL HOSPITAL Address: CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uraemia — INTERVAL BETWEEN ONSET AND DEATH: 10 days
DUE TO
199.2
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Carcinomatosis — 4 mos
DUE TO
(c): Original site undetermined

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 10, 1958, to Dec. 11, 1958, that I last saw the deceased alive on Dec. 10, 1958, and that death occurred at 4:05 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Clay R. Durrett M.D. ADDRESS (Street, city or town, state): 236 Va. Ave Cumberland Md. DATE SIGNED: 12/11/58

PHYSICIAN'S NAME (Type): DR. CLAY DURRETT

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Dec. 15, 1958

22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park

22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: H. Wayne George, Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: DEC 15 '58

24b. REGISTRAR'S SIGNATURE: Esther L. Krantz

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

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FOR STATE HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13150 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

13147 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 2 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 630 Hill Top Drive

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 630 Hill Top Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William; Middle: Raymond; Last: Chapline

4. DATE OF DEATH: Month: Dec. 4, Day: ; Year: 19 58

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 12, 1885

9. AGE (In years last birthday): 73 yrs.

IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Postal Service

10b. KIND OF BUSINESS OR INDUSTRY: U.S.Govt.

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William A. Chapline

14. MOTHER'S MAIDEN NAME: Ida Cookus

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. J. L. Mathews Address: Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Coronary Sclerosis — -----

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. / p. m. Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

DATE SIGNED: Dec. 4, 1958

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Dec.6,1958

22c. NAME OF CEMETERY OR CREMATORY: Elmwood Cemetery

22d. LOCATION (City, town, or county) (State): Shepherdstown, W. Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Byron Kight ADDRESS: Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: DEC 9 '58

24b. REGISTRAR'S SIGNATURE: Arthur L. Frank

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13148

13151 CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Allegany
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland,
c. LENGTH OF STAY IN 1b: 2 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 516 Riehl Avenue

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland,
d. STREET ADDRESS: 516 Riehl Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Helena; Middle: M.; Last: Close

4. DATE OF DEATH: Month: December; Day: 18; Year: 1958

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 5-13-1877

9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homework

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Frostburg, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Daniel Brode

14. MOTHER'S MAIDEN NAME: Wilhelminia Miller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. John Krailing, 516 Riehl Ave., Address Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Macrocytic anemia, Cause indet.,
291X
DUE TO
(b)
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 18 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Hemorrhagic arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m.; Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1940, 19____, to 18 Dec, 1958, that I last saw the deceased alive on 15 Dec, 1958, and that death occurred at 6 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: W. Alfred Van Orma M.D.
ADDRESS (Street, city or town, state): 122 S Centre St. Cumberland Md.
DATE SIGNED: 18 Dec 58

PHYSICIAN'S NAME (Type): W. Alfred Van Ormer, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-20-58
22c. NAME OF CEMETERY OR CREMATORY: Frostburg Memorial Park
22d. LOCATION (City, town, or county): Frostburg (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Beulah H. Wentzel
NAME AND ADDRESS: Hafer Funeral Home 23 E. Main, Frostburg, Md.

24a. REC'D BY REGISTRAR DATE: DEC 22 58
24b. REGISTRAR'S SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 6 FilmG237 1-5-59 et

13227

CERTIFICATE OF DEATH

13149

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): La Vale Md.
c. LENGTH OF STAY IN 1b: 15 Yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LaVale Md.
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Rebecca; Middle: ; Last: Cook

4. DATE OF DEATH: Month: 12; Day: 16; Year: 1958

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: April 14, 1863

9. AGE (In years last birthday): 95 yrs.
IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Hyndman, Pa.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Lowery

14. MOTHER'S MAIDEN NAME: Lydia Sheirer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT: John R. Cook — Address: LaVale MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs
420.0
DUE TO
(b): Arteriosclerotic Heart Disease — ?
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year; Hour o. m. p. m.; 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb, 1922, to Dec, 1958, that I last saw the deceased alive on 12-9, 1958, and that death occurred at M, from the causes and on the date stated above.

ACTUAL SIGNATURE: William P. Jones M.D. — ADDRESS (Street, city or town, state): 442 N. Centre St — DATE SIGNED: 12-14-58

PHYSICIAN'S NAME (Type): William P. Jones — Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12-19-58

22c. NAME OF CEMETERY OR CREMATORY: Cooks Mills Cemetery

22d. LOCATION (City, town, or county) (State): Hyndman, Pa. RD#1 Pa.

23. FUNERAL DIRECTOR'S SIGNATURE: Harvey H. Zeigler — ADDRESS: Hyndman, Pa.

24a. REC'D BY REGISTRAR DATE: DEC 29 '58

24b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 See: Birth Cert. et

13152

CERTIFICATE OF DEATH

13150

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 5 HOURS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL WARWICK & MEMORIAL AVES.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: West Virginia
b. COUNTY: Morgan
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Paw Paw 85 X-3
d. STREET ADDRESS: ---
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First BABY Middle BOY Last CORBETT

4. DATE OF DEATH: Month December Day 30, Year 19 58

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: DECEMBER 30, 1958

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours 5 Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): CUMBERLAND, MD.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: ROBERT E. CORBETT

14. MOTHER'S MAIDEN NAME: BEVERLY JANE HERRELL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: MEMORIAL HOSPITAL Address: CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity (16 wks) — INTERVAL BETWEEN ONSET AND DEATH: 5 hrs.
776X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec. 30, 1958 to Dec 30, 1958 that I last saw the deceased alive on Dec 30, 1958, and that death occurred at 235 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: W Pope Hodges M.D.

ADDRESS (Street, city or town, state): Cumberland, Md.

DATE SIGNED: 12/30/58

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

22b. DATE THEREOF: 12-31-58

22c. NAME OF CEMETERY OR CREMATORY: Memorial Hospital

22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

24a. REC'D BY REGISTRAR DATE JAN 2 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

2060253XUO

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13153

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 1 Film 256 12-12-58 et

13151

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 5 Weeks
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 404 Hill Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Donette — Middle: Jean — Last: Crabtree

4. DATE OF DEATH: Month: Dec. — Day: 5 — Year: 1958

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: October 30/58

9. AGE (In years last birthday): yrs.
IF UNDER 1 YEAR: Months: 1 — Days: 7
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Cumberland, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas Crabtree

14. MOTHER'S MAIDEN NAME: Carolyn Sills

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Mrs Carolyn Crabtree, Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs.

7547

DUE TO
(b): Pulmonary Stenosis, — Congenital

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: Dec. 5, 1958

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Dec 8 1958
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
22d. LOCATION (City, town, or county) (State): Cumberland Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Byron Kight
ADDRESS: Cumberland Md.

24a. REC'D BY REGISTRAR: DATE DEC 9 '58

24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

2060233XV5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

M

C

I

62

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13154 CERTIFICATE OF DEATH

13152

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: ALLEGANY — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND

c. LENGTH OF STAY IN 1b: 10 HOURS

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SACRED HEART HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: MARYLAND b. COUNTY: ALLEGANY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND

d. STREET ADDRESS: 122 INDEPENDENCE ST.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First: MARY Middle: DENISE Last: CREEGAN

4. DATE OF DEATH Month: DECEMBER Day: 28 Year: 1958

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: AUGUST 28, 1958

9. AGE (In years last birthday) yrs. — IF UNDER 1 YEAR: Months 4, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: PAUL CREEGAN

14. MOTHER'S MAIDEN NAME: MARY ANN POWERS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: PATIENTS CHART Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days

493X

DUE TO (b)

DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): premature baby, staph. pneumonia at 4 w. oper for strang. hernia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 19 — Hour a. m. p. m.

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August 28, 1958, to December 28, 1958, that I last saw the deceased alive on December 28, 1958, and that death occurred at 10:55PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Elizabeth Brings M.D. — ADDRESS (Street, city or town, state): 55 Greene St. Cumberland — DATE SIGNED: 12/29/58

PHYSICIAN'S NAME (Type): Elizabeth Brings, M.D. — 55 Greene St., Cumberland, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12/31/58

22c. NAME OF CEMETERY OR CREMATORY: S.S. Peter& Paul

22d. LOCATION (City, town, or county): Cumberland (State): Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Ruth E. Silcox ADDRESS: Cumberland Maryland

24a. REC'D BY REGISTRAR DATE JAN 2 '59

24b. REGISTRAR'S SIGNATURE: [illegible]

VS A15 (4)
15M 10/57

2060221XV3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13228

CERTIFICATE OF DEATH

13153

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LAVALE
c. LENGTH OF STAY IN 1b: 18 YEARS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 510 NATIONAL HIGHWAY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X LAVALE
d. STREET ADDRESS: 1510 NATIONAL HIGHWAY
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EMMA — Middle J. — Last DANNECKER

4. DATE OF DEATH: Month DEC — Day 27 — Year 1958

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: MARCH 10, 1873
9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE
10b. KIND OF BUSINESS OR INDUSTRY: HOUSEWIFE
11. BIRTHPLACE (State or foreign country): JOHNSTOWN, PA
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOHN W. WHITFORD
14. MOTHER'S MAIDEN NAME: MARY JANE JENKINS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Address: Ben J Dannecker — 510 National Hwy Lavale, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypertension, Senile — 422.2 — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1940, 19__, to DEC 27, 1958, that I last saw the deceased alive on DEC 25, 1958, and that death occurred at 3:10 P.M., from the causes and an the date stated above.

ACTUAL SIGNATURE: L. B. Matthews M.D. — M.D.
ADDRESS (Street, city or town, state): 49 Green St — DATE SIGNED
PHYSICIAN'S NAME (Type): L. B. Matthews M.D. — Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify)
22b. DATE THEREOF: DEC 30, 1958
22c. NAME OF CEMETERY OR CREMATORY: UNION CEMETERY
22d. LOCATION (City, town, or county) (State): MEYERSDALE, SOMERSET, PA

23. FUNERAL DIRECTOR'S SIGNATURE: W. C. Price — ADDRESS: Meyersdale Pa
24a. REC'D BY REGISTRAR DATE: DEC 30 '58
24b. REGISTRAR'S SIGNATURE: Arthur S. Frank

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13155 CERTIFICATE OF DEATH

13154
Reg. Dist. No.

1 M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

I

1. PLACE OF DEATH a. COUNTY: Allegany — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland, — c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland,
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 212 Washington St.,	d. STREET ADDRESS: 212 Washington St., — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First: SARAH	Middle: EDITH	Last: DAWSON	4. DATE OF DEATH	Month: Dec.	Day: 30,	Year: 1958	
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: Jan. 20, 1888	9. AGE (In years last birthday): 70 yrs.	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife	10b. KIND OF BUSINESS OR INDUSTRY: Own home	11. BIRTHPLACE (State or foreign country): Bedford, Penna.	12. CITIZEN OF WHAT COUNTRY?: U. S. A.
13. FATHER'S NAME: George B. Milburn		14. MOTHER'S MAIDEN NAME: Sue Biddle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No, (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: None	17. INFORMANT: Mr. Edgar J. Dawson — Address: 212 Washington St., Cumb. Md.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Generalized Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 3 years
DUE TO
450.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. I certify that I attended the deceased from ____, 19 57, to 12-27, 19 58, that I last saw the deceased alive on 12-27-, 1958, and that death occurred at 4:27 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James T. Johnson M.D. — ADDRESS (Street, city or town, state): 16 Greene St., — DATE SIGNED: 12-31-58

PHYSICIAN'S NAME (Type): Dr. James T. Johnson — Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial	22b. DATE THEREOF: 1/1/1959	22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Mausoleum	22d. LOCATION (City, town, or county) (State): Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE: Charles L. George — ADDRESS: Cumberland, Maryland		24a. REC'D BY REGISTRAR DATE: JAN 5 '59	24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus	

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13155

Item 1 FilmG236 12-10-58 et

13219 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b: 10 Yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: At home -- 23 Centennial Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 22 Frostburg,
d. STREET ADDRESS: 23 Centennial Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Frank; Middle; Last Dietle
4. DATE OF DEATH: Month December; Day 1st; Year 1958

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept. 14th, 1887
9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer-Street dept.
10b. KIND OF BUSINESS OR INDUSTRY: City of Frbg.
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Dietle
14. MOTHER'S MAIDEN NAME: Christiana Nedro

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 215-26-9344
17. INFORMANT: Address: Mrs. Clara R. Dietle, Frostburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 2 days
443X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Hypertensive Cardiovascular disease — Years
DUE TO
(c): Arteriosclerosis — Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m.; Month; Day; Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov. 15, 1958 to Dec 1, 1958 that I last saw the deceased alive on Dec 1, 1958, and that death occurred at 5:00 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: John B. Davis, M.D.
ADDRESS (Street, city or town, state): 2 Broadway, Frostburg, Md.
DATE SIGNED: 12/2/58
PHYSICIAN'S NAME (Type): John B. Davis, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-3-58
22c. NAME OF CEMETERY OR CREMATORY: Greenville Cemetery
22d. LOCATION (City, town, or county) (State): Pocahontas, Pa.

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph R. Durst,
ADDRESS: Frostburg, Md.
24a. REC'D BY REGISTRAR DATE: DEC 4 '58
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

Item 18 Film 236 12/19/58 ams DR. REITER

Items 11,12 Film G236 12-17-58 et

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13156

CERTIFICATE OF DEATH

13156

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 2HRS-25 MIN.
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: MEMORIAL HOSPITAL-MEMORIAL AVENUE

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 43 WESTERNPORT
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First HARRY Middle Last DOHM

4. DATE OF DEATH: Month 12 Day 9 Year 1958

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: SEPT. 19

9. AGE (In years last birthday): 9 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: HARRY E. DOHM

14. MOTHER'S MAIDEN NAME: CAROLYN GWYNN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Aspiration Pneumonia and — INTERVAL BETWEEN ONSET AND DEATH: 1 day?
DUE TO
(a) 082.3
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
(b) cerebral edema due to viral encephalitis
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cerebral edema

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec 9, 1958, to Dec. 9, 1958, that I last saw the deceased alive on Dec. 9, 1958, and that death occurred at 5:25 A. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: R. A. Reiter, M.D.
ADDRESS (Street, city or town, state): 112 Bedford St., Cumberland, Md.
DATE SIGNED: Dec 9, 1958
PHYSICIAN'S NAME (Type): DR. REITER

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/11/58
22c. NAME OF CEMETERY OR CREMATORY: Philop
22d. LOCATION (City, town, or county) (State): Westernport Md

23. FUNERAL DIRECTOR'S SIGNATURE: E. J. Boal
ADDRESS: Westernport, Md

24a. REC'D BY REGISTRAR DATE: DEC 11 '58

24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13157 CERTIFICATE OF DEATH

13157
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 11 HRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X LONACONING
d. STREET ADDRESS: 20 FURNACESTREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JAMES WILLIAM Middle Last DUCKWORTH

4. DATE OF DEATH: Month DECEMBER Day 6 Year 1958

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: JUNE 7-1878
9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): LONACONING, MD.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: GEORGE DUCKWORTH
14. MOTHER'S MAIDEN NAME: CLEMENTINE PEARCE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage with rt. hemiplegia — INTERVAL BETWEEN ONSET AND DEATH: 15 hours
331X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Hypertensive Vascular Disease — ?
DUE TO (c): Generalized arteriosclerosis — ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5 Dec, 1958, to 6 Dec, 1958, that I last saw the deceased alive on 5 Dec. 1958, 19____, and that death occurred at 11:00 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Walfred Van Ormer M.D.
ADDRESS (Street, city or town, state): 122 S Centre St. Cumberland, Md.
DATE SIGNED: 6 Dec 58
PHYSICIAN'S NAME (Type): W. A. VAN ORMER

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-9-58
22c. NAME OF CEMETERY OR CREMATORY: Memorial Park
22d. LOCATION (City, town, or county) (State): Frostburg Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: E. L. Boal - Westernport, Md.
24a. REC'D BY REGISTRAR DATE: DEC 9 '58
24b. REGISTRAR'S SIGNATURE: Anthony S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13158 CERTIFICATE OF DEATH

Reg. Dist. No. 13158

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 5 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL-WARWICK AND MEMORIAL AVE.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X FLINTSTONE
d. STREET ADDRESS: Green Ridge Forestry Camp
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WAYNARD Middle Oroscoe Last FEDERLINE

4. DATE OF DEATH: Month DECEMBER Day 22 Year 19 58

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5-22-1899
9. AGE (In years last birthday): 59 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Director
10b. KIND OF BUSINESS OR INDUSTRY: State Training School
11. BIRTHPLACE (State or foreign country): SOUTH CAROLINA
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: JOHN R. FEDERLINE
14. MOTHER'S MAIDEN NAME: MARY SLATER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes, (If yes, give war or dates of service): W. W. # 1
16. SOCIAL SECURITY NO.: 247-05-1416
17. INFORMANT: MEMORIAL HOSPITAL — Address: CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Pneumonia	7 days
DUE TO (b)	Chronic Nephritis	6 months
DUE TO (c)	Hypertensive Myocardial Disease	

592X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/2/58, 19____, to 12/22/58, 19____, that I last saw the deceased alive on 12/22/58, 19____, and that death occurred at 9:50P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: R. J. Williams M.D. ADDRESS (Street, city or town, state): Cumberland, Md. DATE SIGNED: 12/22/58

PHYSICIAN'S NAME (Type): DR. RICHARD J. WILLIAMS

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/26/58
22c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
22d. LOCATION (City, town, or county) (State): Spartanburg, So. Carolina

23. FUNERAL DIRECTOR'S SIGNATURE: Charles L. George ADDRESS: Cumberland, Md.
24a. REC'D BY REGISTRAR DATE: DEC 2 9 '58
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13229 Items 1,3 [illegible] 12-15-58 et

CERTIFICATE OF DEATH

Reg. Dist. No. 13159

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Oldtown
c. LENGTH OF STAY IN 1b: 1 Yr.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: "Daughter's home"

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X LaVale
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Isabelle [illegible] Middle: Keefer Last: Felker

4. DATE OF DEATH: Month: December Day: 6th Year: 1958

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: June 1st, 1874

9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Hous ewife

10b. KIND OF BUSINESS OR INDUSTRY: own housework

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Conrad Keefer

14. MOTHER'S MAIDEN NAME: Cordelia Bittner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Maggie Leasure, Oldtown, Md.
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): GASTRO-ENTERITIS — INTERVAL BETWEEN ONSET AND DEATH: 5 days
571.1
DUE TO (b): HEART DISEASE- — 6 months
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): ARTERIOSCLEROSIS — "

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 260x DIABETES MELLITUS

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1958 to 6 DEC, 1958, that I last saw the deceased alive on 10/31, 1958, and that death occurred at 11:50 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D.
ADDRESS (Street, city or town, state): 59 Greene St
DATE SIGNED: 12/8/58
PHYSICIAN'S NAME (Type): S G WEISMAN MD
Cumberland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-9-58
22c. NAME OF CEMETERY OR CREMATORY: White Oak Cemetery
22d. LOCATION (City, town, or county): Somerset County (State): Pa.

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph R. Durst, Frostburg, Md.
ADDRESS:

24a. REC'D BY REGISTRAR
DATE: DEC 10 '58

24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13160

13230 **CERTIFICATE OF DEATH**

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

1. PLACE OF DEATH a. COUNTY: Allegany — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Morantown, Frostburg	c. LENGTH OF STAY IN 1b: 50 yrs.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Morantown, Frostburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS: / e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print)	First: Nazzereno	Middle:	Last: Femi	4. DATE OF DEATH	Month: December	Day: 1st,	Year: 1958	
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: April 29th, 1884	9. AGE (In years last birthday): 74 yrs.	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Farmer	10b. KIND OF BUSINESS OR INDUSTRY: Farming	11. BIRTHPLACE (State or foreign country): Italy	12. CITIZEN OF WHAT COUNTRY?: Italy					
13. FATHER'S NAME: Santino Femi	14. MOTHER'S MAIDEN NAME: Unknown							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 215-20-5383	17. INFORMANT: Ted Femi, LaVale, Md. Address						

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 Days

443X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): Hypertensive Cardiovascular Renal — Years

DUE TO

(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour / Month, Day, Year	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
o. m. p. m. 19			

21. I certify that I attended the deceased from June, 1950, to Dec 1st, 1958, that I last saw the deceased alive on Dec 1, 1958, and that death occurred at 9:00 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: John B. Davis, M.D. — ADDRESS (Street, city or town, state): 2 Broadway, Frostburg, Md. — DATE SIGNED: 12/2/58

PHYSICIAN'S NAME (Type): John B. Davis, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	12-4-58	St. Michael's Cemetery	Frostburg, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Joseph R. Durst, Frostburg, Md.	DEC 4 '58	Arthur P. Kane

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13161

13159 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 40yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland, b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland, Md
d. STREET ADDRESS: 307 Pulaski Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Wilbert — Middle: Edward — Last: Firlie

4. DATE OF DEATH: Month: Dec. — Day: 20, — Year: 1958

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 19, 1907

9. AGE (In years last birthday): 51 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Prop. Bowling Alley

10b. KIND OF BUSINESS OR INDUSTRY: Part Owner

11. BIRTHPLACE (State or foreign country): Midland, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Peter V. Firlie

14. MOTHER'S MAIDEN NAME: Margaret Dugan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Dolores C. Firlie Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Ruptured Esophageal Varices — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.
DUE TO
(b): Cirrhosis of the liver — unknown
DUE TO
(c): and other type dyscrasia & multiple abscesses of kidneys — unknown

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

581.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arachnoiditis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1 Nov, 1958, to 20 Dec, 1958, that I last saw the deceased alive on 20 Dec, 1958, and that death occurred at 2.40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: S. G. Weisman M.D. — ADDRESS (Street, city or town, state): 59 GREENE ST — DATE SIGNED: 12/20/58

PHYSICIAN'S NAME (Type): S. G. WEISMAN M.D. CUMBERLAND, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12-23-58

22c. NAME OF CEMETERY OR CREMATORY: ST. Peter & Paul Cem.

22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: James F. Scarpelli Cumberland, Md.

James F. Scarpelli

24a. REC'D BY REGISTRAR — DATE: DEC 23 '58

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13160 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13162
Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): La Vale
d. STREET ADDRESS: 916 Forrest Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Floyd — Middle: Ivan — Last: Flesher
4. DATE OF DEATH: Month: Dec. — Day: 24 — Year: 1958
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb. 20. 1902
9. AGE (In years last birthday): 56 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Standard Oil Co.
11. BIRTHPLACE (State or foreign country): Cold Run, Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Dennis Flesher
14. MOTHER'S MAIDEN NAME: Bertha McClintock
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 214-05-5716
17. INFORMANT: Mrs. Frances Flesher — Address: 916 Forrest Street La Vale, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Coronary Sclerosis
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year: 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED
EXAMINER'S NAME (Type): Benedict Skitarelic, M.D. — Dec. 24, 1958

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/27/1958
22c. NAME OF CEMETERY OR CREMATORY: Trinity Lutheran Cemetery
22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: John J. Hafer, Cumberland, Maryland
24a. RECORDED BY REGISTRAR DATE: DEC 31 '58
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13161

CERTIFICATE OF DEATH

13163

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 26 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 526 Cumberland Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: Arnold — Last: Gunther

4. DATE OF DEATH: Month: December — Day: 16 — Year: 1958

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 21, 1894

9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bacteriologist

10b. KIND OF BUSINESS OR INDUSTRY: State Md. State Health Dept.

11. BIRTHPLACE (State or foreign country): Maryland, Baltimore

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Joseph Gunther (Deceased)

14. MOTHER'S MAIDEN NAME: Regina Dumbler (Deceased)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 215-36-9514

17. INFORMANT: Patients Chart
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute left ventricular failure — INTERVAL BETWEEN ONSET AND DEATH: Instantly
592 x

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Myocardial fibrosis; coronary arteriosclerosis — ?

DUE TO

(c) Chronic, diffuse glomerular nephritis ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertension, uremia, generalized arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov. 19, 1958, to Dec. 16, 1958, that I last saw the deceased alive on Dec. 15, 1958, and that death occurred at 12:35 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state): 50 Pershing St., Cumberland, Md. — DATE SIGNED: 12/17/58

PHYSICIAN'S NAME (Type): S.M Jacobson, M.D. — Baltimore Road

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: 12-18-58
22c. NAME OF CEMETERY OR CREMATORY: New Cathedral Cem.
22d. LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Burial 12-19-58 James F. Scarpelli Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: DEC 22 '58

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

James F. Scarpelli

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

DR. IAMES

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13164

13162 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 15 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: PA.
b. COUNTY: BEDFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HYNDMAN Rural 75 X-3
d. STREET ADDRESS: Londonderry Township
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
ETHEL	A	HAINES	DEC.	1	1958

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
FEMALE	White		APRIL 13, 1886	72 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HWFE.		MD.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
DENNIS BEALL	MARY MC GEE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	None	MEMORIAL HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 2 wks
DUE TO
443X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Hypertensive Cardiovascular Renal — 5 yrs
DUE TO
(c): Generalized Arteriosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I attended the deceased from Nov 16, 19 58 to Dec 1, 19 58 that I last saw the deceased alive on Dec 1, 19 58, and that death occurred at 6.00A. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: William P. Iames M.D. — ADDRESS (Street, city or town, state): 441 N. Centre St — DATE SIGNED: 12-2-58

PHYSICIAN'S NAME (Type): DR. WM. P. IAMES — Cumberland, Md

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Dec. 3, 1958	Greenmount Cemetery	Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Harvey N. Zeigler	Hyndman, Pa.	DEC 4 '58	Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13163 CERTIFICATE OF DEATH

13165
Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 28 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 307 Pulaski Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ardie — Middle: W. — Last: Hall
4. DATE OF DEATH: Month: December — Day: 23 — Year: 1958
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3/6/1893
9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Custom tailor- 40
10b. KIND OF BUSINESS OR INDUSTRY: yrs in Cumb, Md
11. BIRTHPLACE (State or foreign country): West Virginia
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Lonnie Hall (Deceased)
14. MOTHER'S MAIDEN NAME: Mary Veech (Deceased)
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 215-20-6313
17. INFORMANT: Patients Chart — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of the bronchus — INTERVAL BETWEEN ONSET AND DEATH: 6 months
162.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11-3-58, 19__, to 12-23-, 1958, that I last saw the deceased alive on 12-23-, 1958, and that death occurred at 5:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: L. Brings M.D.
ADDRESS (Street, city or town, state): 57 Green Street Cumberland Md
DATE SIGNED:
PHYSICIAN'S NAME (Type): Lewis Brings, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Dec 26/58
22c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
22d. LOCATION (City, town, or county) (State): Cumberland Maryland

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Ruth E. Silcox Cumberland Maryland
24a. REC'D BY REGISTRAR DATE: DEC 29 '58
24b. REGISTRAR'S SIGNATURE: Catherine L. Trawick

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13164 # MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7, Film G-237 1/16/59.cac.

13166

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1. PLACE OF DEATH a. COUNTY: Allegany	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland	b. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland	c. LENGTH OF STAY IN 1b: 16 hours	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sacred Heart Hospital		d. STREET ADDRESS: Brooks Hotel 202 Baltimore Ave.	e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Norman	Richard	Hall	12	30	1958

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married	June 25,1904	54 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carman Helper	Railroad	Cumber. Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William Hall	Ida ???

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
yes	War II		William Hall, Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 18 Hrs.

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Coronary Sclerosis

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fatty Changes of Liver

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour / Month, Day, Year	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
o. m. p. m. 19			

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: Dec. 30, 1958

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Jan.2,1959	Hillcrest Burial Park	Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md.	JAN 2 '59	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13167

13165 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 63 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL MEMORIAL & WARWICK AVENUES

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND
d. STREET ADDRESS: 511 BEDFORD STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARIE — Middle A. — Last HARPER

4. DATE OF DEATH: Month DECEMBER — Day 5, — Year 19 58.

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: NOVEMBER 18,1890

9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: ADOLPH MACKENROTH

14. MOTHER'S MAIDEN NAME: ELIZABETH HUPFELD or ELISE HUPFELD

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: MEMORIAL HOSPITAL - CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma Lower Sigmoid and
153.3
DUE TO
(b) Return & Metastases to Abdomen
DUE TO
(c) Contents

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Nov 56.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11-13- 19 58, to 12-5- 19 58, that I last saw the deceased alive on 12-4- 19 58, and that death occurred at 9:00A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: W. F. Williams M.D. — ADDRESS (Street, city or town, state): Cumberland Md — DATE SIGNED: 12/5/58

PHYSICIAN'S NAME (Type): DR. W. F. WILLIAMS

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12/7/58

22c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park

22d. LOCATION (City, town, or county) (State): Cumberland Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Ruth E. Silcox Cumberland Maryland

24a. REC'D BY REGISTRAR — DATE: DEC 8 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 are to be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13166

CERTIFICATE OF DEATH

13168

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 131 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 22 FROSTBURG
d. STREET ADDRESS: 9 ORMOND STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ELNORE Middle GALE Last HARTIG

4. DATE OF DEATH: Month DECEMBER Day 13 Year 1958

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: OCT. 25

9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): PENNA

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: DAVID WEIGLE

14. MOTHER'S MAIDEN NAME: CEVILLE KNEPPER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Generalized Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 12 months.
DUE TO
(b): adenocarcinoma, Left breast — yr. 1957
DUE TO
(c):

170X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec. 7, 1958, to Dec. 13, 1958, that I last saw the deceased alive on 12 Dec, 1958, and that death occurred at 9:35 AM from the causes and on the date stated above.

ACTUAL SIGNATURE: W. Alfred Van Ormer M.D. — ADDRESS (Street, city or town, state): 122 S. Centre St. Cumberland, Md. — DATE SIGNED: 13 Dec 1958

PHYSICIAN'S NAME (Type): WILLIAM A. VAN ORMER

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12-16-58

22c. NAME OF CEMETERY OR CREMATORY: Frostburg Memorial Park, Frostburg

22d. LOCATION (City, town, or county) (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Ruth H. Montesano — ADDRESS: Hafer Funeral Home 23 E. Main, Frostburg, Md.

24a. REC'D BY REGISTRAR — DATE: DEC 18 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4 Film G237 12-29-58 et

13169

13167

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 122 Wilmont Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland Md
d. STREET ADDRESS 122 Wilmont Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Mary — Last Hausman

4. DATE OF DEATH Month December Day 12, Year 1958

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 5/23/86
9. AGE (In years last birthday) 72 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Home.
11. BIRTHPLACE (State or foreign country) Lonaconing Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William R. Hausman
14. MOTHER'S MAIDEN NAME Mary Wilson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None.
17. INFORMANT Address Miss Sarah Hausman Cumb. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Stomach with Metastasis — INTERVAL BETWEEN ONSET AND DEATH one year
DUE TO
1517
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from November 19 57 to December 12 19 58, that I last saw the deceased alive on September 19 58, and that death occurred at 1 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE J. F. Johnson Jr. M.D. ADDRESS (Street, city or town, state) 16 Greene St, Cumberland Md DATE SIGNED 12-14-58

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 12/14/58
22c. NAME OF CEMETERY OR CREMATORY Greenmount Cem.
22d. LOCATION (City, town, or county) Cumberland (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc. ADDRESS Cumb. Md.
24a. REC'D BY REGISTRAR DATE DEC 16 '58
24b. REGISTRAR'S SIGNATURE Clinton L. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13168 CERTIFICATE OF DEATH

13170
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 1 HOUR
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WARWICK AND MEMORIAL HOSPITAL-MEMORIAL AVE.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND
d. STREET ADDRESS: 831 COLUMBIA AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First AUGUSTUS Middle A. Last HEBB

4. DATE OF DEATH: Month DECEMBER Day 19 Year 19 58

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: MAY 2, 1901
9. AGE (In years last birthday): 57 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bobbin Dept - Celanese Corp of AM.
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: JACOB E. HEBB
14. MOTHER'S MAIDEN NAME: ANNA M. CHANEY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 214-07-2528
17. INFORMANT: MEMORIAL HOSPITAL Address: CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 da.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO: Myocardial Infarction — 7 da.
(c): Rhumatic heart disease — 43 yr.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): none

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): none
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from September 11, 1950 to 12/19, 1958, that I last saw the deceased alive on December 19, 1958, and that death occurred at 6:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: James H. Hallinan M.D.
ADDRESS (Street, city or town, state): 140 Bedford St. Cumberland, Maryland
DATE SIGNED: 12/20/58
PHYSICIAN'S NAME (Type): DR. JAMES HALLINAN

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/22/58
22c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
22d. LOCATION (City, town, or county) (State): Cumberland Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Ruth E. Silcox Cumberland Maryland
24a. REC'D BY REGISTRAR DATE: DEC 23 '58
24b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 are to be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G237 1-7-59 et

13171

13169

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 33yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: I29 Springdale Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland 02
d. STREET ADDRESS: I29 Springdale Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Frank — Middle: H. — Last: Herbaugh

4. DATE OF DEATH: Month: I2- — Day: 26- — Year: 1958

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 29, I894

9. AGE (In years last birthday): 63 64 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Tube Builder

10b. KIND OF BUSINESS OR INDUSTRY: Rubber Factory

11. BIRTHPLACE (State or foreign country): Three Churches, W. Va.

12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: Wm. B. Herbaugh

14. MOTHER'S MAIDEN NAME: Elizabeth Mc Bride

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): War I

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Fay Herbaugh I29 Springdale St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Abutant
DUE TO (b): Coronary Arteriosclerosis — 5 yrs
DUE TO (c):

420.1

Conditions, if any, which gove rise to immediote couse (a), stating the underlying couse last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerotic Myocardial Disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4/6/52, 19____, to 12/24/58, 19____, that I last saw the deceased alive on 12/24/58, 19____, and that death occurred at 11:40A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: R J Williams M.D. — ADDRESS (Street, city or town, state): Cumberland Md — DATE SIGNED: 12/29/58

PHYSICIAN'S NAME (Type): Richard J. Williams — I22 S. Centre St Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: I2-30-58

22c. NAME OF CEMETERY OR CREMATORY: Wesley Chapel Cem

22d. LOCATION (City, town, or county) (State): Levels W.Va.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: James F. Scarpelli Cumberland, Md.

24a. REC'D BY REGISTRAR — DATE: DEC 30 '58

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13172

13220 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b: 3 hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Miners Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 22 Frostburg
d. STREET ADDRESS: 66 W. College Ave.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First NANCY — Middle BROWN — Last HITCHINS

4. DATE OF DEATH: Month Dec. — Day 26, — Year 19 58

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan. 2, 1875
9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housework
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Hitchins
14. MOTHER'S MAIDEN NAME: Sally Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — Address: Mrs. Rachel Dunn, Frostburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Gastro Enteritis — INTERVAL BETWEEN ONSET AND DEATH: 4 days
571.1
DUE TO (b): Arteria-Sclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Senility

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec 26, 19 58 to Dec 26, 19 58, that I last saw the deceased alive on Dec 26, 19 58, and that death occurred at 11:35 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W. O. McLane M.D. — ADDRESS (Street, city or town, state): E. Main St., — DATE SIGNED: Dec 27 1958

PHYSICIAN'S NAME (Type): W. O. McLane, M. D. — Frostburg, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-29-58
22c. NAME OF CEMETERY OR CREMATORY: F'burg. Memorial Park
22d. LOCATION (City, town, or county) (State): Frostburg, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: J. R. Durst, Frostburg, Md.

24a. REC'D BY REGISTRAR — DATE: DEC 29 '58
24b. REGISTRAR'S SIGNATURE: Arthur L. Mills

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the coroner director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13173

13170

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 29 HRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND
d. STREET ADDRESS: BOWMAN'S ADDITION
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First KIRK — Middle GEORGE — Last HOTT

4. DATE OF DEATH: Month DECEMBER — Day 6 — Year 1958

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MAY 22 1875

9. AGE (In years last birthday): 83 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Odd jobs

11. BIRTHPLACE (State or foreign country): W.VA.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: FAWLER HOTT

14. MOTHER'S MAIDEN NAME: SALLY SHANHOLTZ

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 220-10-2447A

17. INFORMANT — Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Terminal Cordial failure — INTERVAL BETWEEN ONSET AND DEATH:

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Arteriosclerotic Heart Disease — 2 years

DUE TO (c): Generalized arteriosclerosis — ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5 Dec, 1958, to 6 Dec, 1958, that I last saw the deceased alive on 5 Dec, 1958, and that death occurred at 7:15 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: W. Alfred Van Ormer M.D. — ADDRESS (Street, city or town, state): 122 S. Center St — DATE SIGNED

PHYSICIAN'S NAME (Type): W. A. VAN ORMER — Cumberland, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12/9/58

22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park

22d. LOCATION (City, town, or county) (State): Cumberland Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Ruth E. Silcox Cumberland Maryland

24a. REC'D BY REGISTRAR DATE: DEC 10 '58

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
ISM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13171

CERTIFICATE OF DEATH

13174

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 615 Princeton Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 615 Princeton Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Lorenzo — Middle: Keith — Last: Kearchner

4. DATE OF DEATH: Month: 12 — Day: 3 — Year: 19 58

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JAN. 9, 1894

9. AGE (In years last birthday): 64 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Brakeman

10b. KIND OF BUSINESS OR INDUSTRY: B & O. Railroad

11. BIRTHPLACE (State or foreign country): Fairhope, Penn

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Henry Kearchner

14. MOTHER'S MAIDEN NAME: Sarah Ellen Spagy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): W.W. I

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Effie May Kearchner — Address: 615 Princeton St Cumberland, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 months

DUE TO
(b): Coronary Sclerosis — 5 yrs

DUE TO
(c): Diabetes Mellitus — Unknown

260X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month — Day — Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/2/53, 19____, to 12/5/58, 19____, that I last saw the deceased alive on 12/2/58, 19____, and that death occurred at 7:10 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R.J. Williams M.D. — ADDRESS (Street, city or town, state): Cumberland — DATE SIGNED: 12/5/58

PHYSICIAN'S NAME (Type): R.J. Williams M.D. Cumberland. Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12/6/58

22c. NAME OF CEMETERY OR CREMATORY: I.O.O.F. Cemetery

22d. LOCATION (City, town, or county) (State): Flintstone, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: John J. Hafer. Cumberland. Md.

24a. REC'D BY REGISTRAR DATE: DEC 9 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13172

CERTIFICATE OF DEATH

13175

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 6 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address or location) OR INSTITUTION: MEMORIAL HOSPITAL (WARWICK & MEMORIAL AVES.)

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND
d. STREET ADDRESS: 45 NORTH MECHANIC
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

60

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
ELLA	R.	KEMP	DECEMBER	9	1958

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
FEMALE	WHITE		MARCH 3	72 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		HYNDMAN, PENNSYLVANIA	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
HENRY WELSH	CORA VALENTINE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	None	MEMORIAL HOSPITAL CUMBERLAND, MARYLAND

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Myocardial Infarction	1 wk
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Arteriosclerosis	?
DUE TO (c)	Diabetes Mellitus	?

2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Uremia

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I attended the deceased from 12-3, 1958, to 12-9, 1958, that I last saw the deceased alive on 12-9, 1958, and that death occurred at 5:20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: William P. James, M.D. — ADDRESS (Street, city or town, state): 444 U.S. Center — DATE SIGNED: 12-10-58

1

PHYSICIAN'S NAME (Type): DR. WILLIAM IAMES — Cumberland Md.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Dec. 13, 1958	Cooks Mills Cemetery	Hyndman, Pa. RD#1 Bedford Co.

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Harvey H. Leigler	Hyndman, Pa.	DEC 15 '58	Calvin S. Hoard

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13176

13173 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 29 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Cumberland
d. STREET ADDRESS: Route #4
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Michael — Middle: J. — Last: Kenney

4. DATE OF DEATH: Month: December — Day: 26th — Year: 19 58

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 5, 1883

9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ford Motor Company

10b. KIND OF BUSINESS OR INDUSTRY: Tool Dept.

11. BIRTHPLACE (State or foreign country): Franklin West Virgina

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Patrick J. Kenny

14. MOTHER'S MAIDEN NAME: Bridget Malloy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): War I

16. SOCIAL SECURITY NO.: 362-07-5526

17. INFORMANT: Chart — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia, Chronic Nephritis — INTERVAL BETWEEN ONSET AND DEATH: 6 months
DUE TO (b): Generalized Arteriosclerosis — 4 years
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

446X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jany 58 to Dec 26 1958 that I last saw the deceased alive on Dec 25 1958, and that death occurred at 8:15 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: B. M. Schindler M.D. — ADDRESS (Street, city or town, state): 43 Green St Cumberland Md — DATE SIGNED: 12-26-58

PHYSICIAN'S NAME (Type): B.M. Schindler M.D. — 43 Green Street

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-29-58
22c. NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery
22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: James F. Scarpelli — ADDRESS: Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: DEC 30 '58

24b. REGISTRAR'S SIGNATURE: Arthur L. Frank

James F. Scarpelli

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13177

13174 **CERTIFICATE OF DEATH**

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 18 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL WARWICK & MEMORIAL AVENUES

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: WEST VIRGINIA — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): PAW PAW 85x-3
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First WILBUR — Middle W. — Last LARGENT

4. DATE OF DEATH: Month DECEMBER — Day 26 — Year 1958

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JULY 29, 1902

9. AGE (In years last birthday): 56 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ASST Supt.

10b. KIND OF BUSINESS OR INDUSTRY: ROAD COMMISSION

11. BIRTHPLACE (State or foreign country): PAW PAW, W. VA.

12. CITIZEN OF WHAT COUNTRY: U. S. A.

13. FATHER'S NAME: JOHN R. LARGENT

14. MOTHER'S MAIDEN NAME: AMANDA DEFFENBAUGH

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 737-07-5965

17. INFORMANT — Address: MEMORIAL HOSPITAL - CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Embolism — INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Cerebral Hemorrhage. — INTERVAL BETWEEN ONSET AND DEATH: ,
DUE TO
(c): Pan Paritis old. — INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. / p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec 8, 1958, to Dec 26, 1958, that I last saw the deceased alive on Dec. 22, 1958, and that death occurred at 6:35 A. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: W. F. Williams M.D. — ADDRESS (Street, city or town, state): Cumberland Md. — DATE SIGNED: 12/26/58

PHYSICIAN'S NAME (Type): DR. W. F. WILLIAMS

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 12/29/58

22c. NAME OF CEMETERY OR CREMATORY: CAMP HILL

22d. LOCATION (City, town, or county) (State): PAW PAW, W. VA.

23. FUNERAL DIRECTOR'S SIGNATURE: Parks Funeral Home — ADDRESS: Berkeley Spgs. W. Va.

24a. REC'D BY REGISTRAR DATE: DEC 29 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Rivers

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13178

13175 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 409 Ascension Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JAMES — Middle EDWARD — Last LASHLEY

4. DATE OF DEATH: Month December — Day 27 — Year 1958

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 20, 1904

9. AGE (In years last birthday): 54 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver

10b. KIND OF BUSINESS OR INDUSTRY: Gehauf's Grocery

11. BIRTHPLACE (State or foreign country): Cumberland, Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William Lashley (Deceased)

14. MOTHER'S MAIDEN NAME: Hilda I. Winter (Deceased)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW II

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Bernard Gehauf
Address: 409 Ascension Street Cumberland, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Acute
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov. 15, 1958 to Dec. 27, 1958, that I last saw the deceased alive on Nov. 15, 1958, and that death occurred at 1:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Clay E. Durrett M.D. — ADDRESS (Street, city or town, state): 236 Va. Ave. Cumberland, Md. — DATE SIGNED: 12/30/58

PHYSICIAN'S NAME (Type): Clay E. Durrett M.D. 236 Virginia Avenue Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12/30/58

22c. NAME OF CEMETERY OR CREMATORY: Mt. Herman Meth. Cemetery

22d. LOCATION (City, town, or county) (State): Allegany County, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: John J. Hafer — ADDRESS: Cumberland, Maryland

24a. REC'D BY REGISTRAR — DATE: JAN 2 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13179

13176 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 40 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 226 Pear St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 226 Pear St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BERTHA Middle MAE Last LEAMON

4. DATE OF DEATH: Month Dec. Day 5, Year 19 58

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: June 11, 1902
9. AGE (In years last birthday): 56 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): West Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Richard Maphis
14. MOTHER'S MAIDEN NAME: Magdaline (?)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. Paul Morin — Address: Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: prior
DUE TO
420.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerotic Heart Disease — 5 yrs
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Bronchitis, Acute
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12/2, 19 58 to 12/5, 19 58 that I last saw the deceased alive on 12/2, 19 58, and that death occurred at 8 00 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: A. Weisman M.D. — ADDRESS (Street, city or town, state): 59 O'Reeve ST — DATE SIGNED: 12/5/58

PHYSICIAN'S NAME (Type): S. G. WEISMAN MD Cumberland, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Dec. 7, 1958
22c. NAME OF CEMETERY OR CREMATORY: Greenmount Cemetery
22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Byron Kight — ADDRESS: Cumberland, Md.
24a. REC'D BY REGISTRAR DATE: DEC 9 '58
24b. REGISTRAR'S SIGNATURE: Arthur L. Frame

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13177

CERTIFICATE OF DEATH

13180

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 3 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND
d. STREET ADDRESS: 506 SHERIDAN PLACE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN — Middle JOSEPH — Last LEASURE

4. DATE OF DEATH: Month DECEMBER — Day 4 — Year 19 58

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: OCT. 6, 1882

9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired City Employee
10b. KIND OF BUSINESS OR INDUSTRY: Street Dept.

11. BIRTHPLACE (State or foreign country): CUMBERLAND, MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Alexander LEASURE

14. MOTHER'S MAIDEN NAME: Frances BRINKER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-05-4421

17. INFORMANT — Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Left cerebral Haemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 5 days

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Right Hemiplegia — 5 days

DUE TO (c): Arteriosclerosis — 5 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov. 30, 1958, to Dec. 4, 1958, that I last saw the deceased alive on Dec 3, 1958, and that death occurred at 7:30 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Clay P. Durrett M.D. — ADDRESS (Street, city or town, state): 736 Va. Ave Cumberland — DATE SIGNED: 12/4/58

PHYSICIAN'S NAME (Type): CLAY DURRETT

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12/6/58

22c. NAME OF CEMETERY OR CREMATORY: Camp Hill Cem.

22d. LOCATION (City, town, or county) (State): Paw Paw W. Va

23. FUNERAL DIRECTOR'S SIGNATURE: Louis Stein Inc. — ADDRESS: Cumb Md

24a. REC'D BY REGISTRAR DATE: DEC 8 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13181

13178 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 3 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WARWICK AND MEMORIAL HOSPITAL-MEMORIAL AVE.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 82 CUMBERLAND
d. STREET ADDRESS: HAZEN ROAD
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First LOTTIE — Middle M. — Last LEASURE

4. DATE OF DEATH: Month DECEMBER — Day 20 — Year 1958

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: SEPTEMBER 1 1882

9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: GEORGE BRANT

14. MOTHER'S MAIDEN NAME: JULIA ANN OSTER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: MEMORIAL HOSPITAL — Address: CUMBERLAND, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 4-yrs.
DUE TO
(b): Chronic Nephritis — 4-yrs.
DUE TO
(c): Uremia — 24-hrs.

592x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Carcinoma of Cervix

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/6/57, 19____, to 12/20/58, 19____, that I last saw the deceased alive on 12/20/58, 19____, and that death occurred at 10:50 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R H Williams M.D. — ADDRESS (Street, city or town, state): Cumberland Md — DATE SIGNED: 12/21/58

PHYSICIAN'S NAME (Type): DR. RICHARD J. WILLIAMS

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12/23/1958

22c. NAME OF CEMETERY OR CREMATORY: Zion Memorial Cemetery

22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Byron Kight — ADDRESS: Cumberland, Md.

24a. REGISTRAR'S DATE: DEC 29 '58

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13182

13231 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) McCoole

c. LENGTH OF STAY IN 1b: 37 yrs.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) McCoole

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION McCoole

d. STREET ADDRESS McCoole

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Leonard Middle: Russell Last: LLewellyn

4. DATE OF DEATH Month: Dec. Day: 23 Year: 1958

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 15, 1878

9. AGE (In years last birthday): 80 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farm Work

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Llewellyn

14. MOTHER'S MAIDEN NAME: Sarah Loar

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Charles LLewellyn Address: McCoole

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Uremia - Comatosed. — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

DUE TO

593X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): Nephritis, Prostatitis w/ obstruction — 6 years

DUE TO

(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypostatic pneumonia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 1916, to Dec 23, 1958, that I last saw the deceased alive on 12-23-58, 19____, and that death occurred at 5:30 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D.

ADDRESS (Street, city or town, state): Keyser W Va

DATE SIGNED: 12-25-58

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Dec. 26, 1958

22c. NAME OF CEMETERY OR CREMATORY: Meese Cem.

22d. LOCATION (City, town, or county) (State): Allegany Co. Md

23. FUNERAL DIRECTOR'S SIGNATURE: E. L. Boor — ADDRESS: Westernport, Md

24a. REC'D BY REGISTRAR DATE: DEC 29 '58

24b. REGISTRAR'S SIGNATURE: Curtis S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13183

13179 **CERTIFICATE OF DEATH**

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 15 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WARWICK AND MEMORIAL HOSPITAL-MEMORIAL AVE.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND 02
d. STREET ADDRESS: 54 N. MECHANIC ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HENRY — Middle HAMILTON — Last LOWE

4. DATE OF DEATH: Month DECEMBER — Day 11 — Year 19 58

5. SEX: MALE

6. COLOR OR RACE: COLORED

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: NOVEMBER 28 1893

9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): WEST INDIES

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: FELIX, LOWE

14. MOTHER'S MAIDEN NAME: JULIA STENNETT

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 213-10-5143

17. INFORMANT: MEMORIAL HOSPITAL — Address: CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): uremia — INTERVAL BETWEEN ONSET AND DEATH: 4 or 5 d.
DUE TO
153.8
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Intestinal obstruction — 10 days.
DUE TO
(c) Adenocarcinoma of colon — Few months.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour — o. m. p. m. — Month — Day — Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11-26, 19 58, to 12-11, 19 58 that I last saw the deceased alive on 12-10, 19 58, and that death occurred at 4:05 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: A. Mirkin M.D. — ADDRESS (Street, city or town, state): 115 So. Centre St. Cumberland Md — DATE SIGNED: 12/11/58

PHYSICIAN'S NAME (Type): DR, A. J. MIRKIN

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12/15/58

22c. NAME OF CEMETERY OR CREMATORY: Mt. Lawn Cem.

22d. LOCATION (City, town, or county) (State): Sharon Hill Penna

23. FUNERAL DIRECTOR'S SIGNATURE: Louis Stein Inc — ADDRESS: Cumb Md

24a. REC'D BY REGISTRAR DATE: DEC 16 '58

24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

1

FOR STATE HEALTH DEPT.

C M

60

I

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13180

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13184

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland 02
d. STREET ADDRESS: 702 Montreal Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Richard Leroy; Middle: ; Last: Maiers

4. DATE OF DEATH: Month: Dec.; Day: 20; Year: 1958

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 18, 1958

9. AGE (In years last birthday): yrs.

IF UNDER 1 YEAR: Months: 3; Days:
IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Cumberland, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Richard Leo Maires

14. MOTHER'S MAIDEN NAME: Helen Ruppenkamp

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Address: Richard Leo Maiers Cumberland, d.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Lobar Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.
DUE TO (b): 490 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Terminal aspiration of Stomach Contents

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☒ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: Dec. 20, 1958

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Dec. 22, 1958
22c. NAME OF CEMETERY OR CREMATORY: St. Mary Cem.
22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: James F. Scarpelli
ADDRESS: Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: DEC 23 '58
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

James F. Scarpelli 2060141XV3

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 2/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13185

13232 CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lonaconing
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: West Main

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): × Lonaconing
d. STREET ADDRESS: West Main
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Rachel — Middle — Last Marshall
4. DATE OF DEATH: Month December — Day 15 — Year 1958
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: March 1, 1873
9. AGE (In years last birthday): 85 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Lonaconing, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Peter Smith
14. MOTHER'S MAIDEN NAME: Jane Scott
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Jane Marshall "Daughter" — Address: Lonaconing, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Ischemia + insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 7 days
DUE TO (b): Arteriosclerosis — years
DUE TO (c): #
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec. 12, 1956, to Dec. 15, 1958, that I last saw the deceased alive on Dec. 12, 1958, and that death occurred at 7 a.m., from the causes and on the date stated above.

ACTUAL SIGNATURE: Leslie R. Miles Jr. M.D. — ADDRESS (Street, city or town, state): MAIN ST — DATE SIGNED: DEC. 16, 1958
PHYSICIAN'S NAME (Type): LESLIE R. MILES JR. M.D. LONACONING MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/17/58
22c. NAME OF CEMETERY OR CREMATORY: Memorial Park
22d. LOCATION (City, town, or county) (State): Frostburg Md.

23. FUNERAL DIRECTOR'S SIGNATURE: George Eichhorn — ADDRESS: Lonaconing, Md.
24a. REC'D BY REGISTRAR DATE: DEC 18 '58
24b. REGISTRAR'S SIGNATURE: Arthur S. Rinard

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13181 **CERTIFICATE OF DEATH** 13186

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 323 Fayette St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 323 Fayette St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Sarah — Middle Anna — Last Marston

4. DATE OF DEATH: Month Dec. — Day 9. — Year 1958

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Nov. 27, 1877
9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic work
10b. KIND OF BUSINESS OR INDUSTRY: Private homes
11. BIRTHPLACE (State or foreign country): Edinburg, Va.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: John Siebert
14. MOTHER'S MAIDEN NAME: Amanda Bowers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 214-36-6540
17. INFORMANT: Address: Mrs. Marguerite Robb, Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Cardio-vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 3 years
422.1
DUE TO
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 6, 1958 to Dec 9, 1958 that I last saw the deceased alive on Dec 8, 1958, and that death occurred at 5:35 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Ralph W. Ballin, M.D. — ADDRESS (Street, city or town, state): 62 Greene St, — DATE SIGNED: Dec. 10, 1958

PHYSICIAN'S NAME (Type): Ralph W. Ballin M. D. — Cumberland, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Dec. 11, 1958
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: H. Wayne George, — ADDRESS: Cumberland, Md.
24a. REC'D BY REGISTRAR DATE: DEC 12 '58
24b. REGISTRAR'S SIGNATURE: Arthur I. Kime

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 Film 236 12-15-58 et

13187

13182

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 1 DAY
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL WARWICK & MEMORIAL AVES.,

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: WEST VIRGINIA — b. COUNTY: NEW HAMPSHIRE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): PAW PAW 85 x 3
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First ETHEL — Middle I — Last MC COOLE

4. DATE OF DEATH: Month DECEMBER — Day 5 — Year 1958

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: SEPTEMBER 14

9. AGE (In years last birthday): 67 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: SHERMAN,

14. MOTHER'S MAIDEN NAME: Minnie Lamb

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: MEMORIAL HOSPITAL, — Address: CUMBERLAND, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arterio Sclerotic Cardio — ?
DUE TO
(c): Vascular disease — ?

422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12-5-58 to 12-7-58 that I last saw the deceased alive on 12-6-58, and that death occurred at 4:15 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: W. F. Williams M.D. — ADDRESS (Street, city or town, state): 122 B. Lenton St Cumberland Md — DATE SIGNED: 12-7-58

PHYSICIAN'S NAME (Type): DR. W. F. WILLIAMS

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — 22b. DATE THEREOF: 12/10/58 — 22c. NAME OF CEMETERY OR CREMATORY: ST MARYS CEM. — 22d. LOCATION (City, town, or county): RURAL CUMBERLAND (State): MD

23. FUNERAL DIRECTOR'S SIGNATURE: PARKS FUNERAL HOME — ADDRESS: BERKELEY SPGS W. VA.

24a. REC'D BY REGISTRAR DATE: DEC 10 '58 — 24b. REGISTRAR'S SIGNATURE: Arthur L. Kines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13188

13233 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt. Savage
c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Mt. Savage
d. STREET ADDRESS: Church Hill
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Isabel; Middle: Veronica; Last: McDermitt

4. DATE OF DEATH: Month: December; Day: 21st; Year: 1958

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 31st, 1874

9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret.-Postal Employee

10b. KIND OF BUSINESS OR INDUSTRY: Post Office

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Francis B. McDermitt

14. MOTHER'S MAIDEN NAME: Mary C. O'Brien

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Catherine Copleston, Mt. Savage, Md.
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: about 20 yrs.
420.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m.; Month; Day; Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from MAY, 1954, to 12/21, 1958, that I last saw the deceased alive on 12/21/58, 19____, and that death occurred at 10:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D.
ADDRESS (Street, city or town, state): 48 Broadway
DATE SIGNED: 12/27/58

PHYSICIAN'S NAME (Type): MARTIN M. ROTHSTEIN M.D. Frostburg Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-24-58
22c. NAME OF CEMETERY OR CREMATORY: St. Patricks Cemetery
22d. LOCATION (City, town, or county) (State): Mt. Savage, Md.

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Joseph R. Durst, Frostburg, Md.

24a. REC'D BY REGISTRAR DATE: DEC 29 58

24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13,14 FilmG237 1-5-59 et

13189

13183

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 36 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Little Orleans
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

62

3. NAME OF DECEASED (Type or print): First: Nellie; Middle: ; Last: McDonald

4. DATE OF DEATH: Month: 12; Day: 23; Year: 1958

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8/10/90

9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James W. Martin

14. MOTHER'S MAIDEN NAME: Emiline Sipes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Husband-George McDonald — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cancer of the breast — INTERVAL BETWEEN ONSET AND DEATH: 6 years
DUE TO
170X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12-3, 1958, to 12-23 1958, that I last saw the deceased alive on 12-22, 1958, and that death occurred at 3:40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: L Brings M.D.

ADDRESS (Street, city or town, state): 57 Green St., Cumberland, Md.

DATE SIGNED: 12-23-58

PHYSICIAN'S NAME (Type): Lewis Brings, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12.27.58

22c. NAME OF CEMETERY OR CREMATORY: Fairview Christian

22d. LOCATION (City, town, or county) (State): Fairview Bedford Penna.

23. FUNERAL DIRECTOR'S SIGNATURE: Howard F. Stone Hancock Md — ADDRESS:

24a. REC'D BY REGISTRAR DATE: DEC 30 '58

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13190

13184 CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland,
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 412 Lehigh St.,

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland,
d. STREET ADDRESS: 1 412 Lehigh St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM — Middle — Last McFARLAND

4. DATE OF DEATH: Month Dec. — Day 30, — Year 1958

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 13, 1870

9. AGE (In years last birthday): 88 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Policeman

10b. KIND OF BUSINESS OR INDUSTRY: City of Cumberland

11. BIRTHPLACE (State or foreign country): Lonaconing, Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: John McFarland

14. MOTHER'S MAIDEN NAME: Margaret Tennant

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No, (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. Agnes T. Love — Address: 412 Lehigh St., Cumb. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Squamous Cell Carcinoma Left Cheek — INTERVAL BETWEEN ONSET AND DEATH: 36 years
190.3
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Direct spread of Carcinoma to brain — 2 wks
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 1, 1940, to December 30, 1958, that I last saw the deceased alive on Dec 29, 1958, and that death occurred at 10 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: R. Rhett Rathbone M.D.
ADDRESS (Street, city or town, state): 122 So. Centre St.
DATE SIGNED
PHYSICIAN'S NAME (Type): R. Rhett Rathbone M. D. — Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1/2/59
22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park
22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: H. Wayne George — ADDRESS: Cumberland, Maryland

24a. REC'D BY REGISTRAR DATE: JAN 5 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG257 12-29-58 et

13185

13191

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 2 HRS. 15 MINS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WARWICK AND MEMORIAL HOSPITAL-MEMORIAL AVE.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 316 FAYETTE STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First WARREN; Middle; Last MELLINGER

4. DATE OF DEATH: Month DECEMBER; Day 19; Year 19 58

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: SEPT. 28, 1869

9. AGE (In years last birthday): 89 yrs.

IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED CITY EMPLOYEE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): GREENCASTLE, PA.

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: WILLIAM G. MELLINGER

14. MOTHER'S MAIDEN NAME: ADALINE-VIRGINIA HAMILL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address: MEMORIAL HOSPITAL CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia, Generalized Arteriolar Sclerosis — INTERVAL BETWEEN ONSET AND DEATH: weeks
DUE TO
(b): Diabetes Mellitus — years
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

260X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour; a. m. p. m.; Month; Day; Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec 19, 19 50, to Dec 19, 19 58, that I last saw the deceased alive on Dec 19, 19 58, and that death occurred at 11:40 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: B. M. Schindler M.D. — ADDRESS (Street, city or town, state): 43 Grant St Cumberland, Md. — DATE SIGNED: 12/22/58

PHYSICIAN'S NAME (Type): DR. B. M. SCHINDLER

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/22/58
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Mausoleum
22d. LOCATION (City, town, or county) (State): Cumberland Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Louis Stein, Inc. — ADDRESS: Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: DEC 23 58

24b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13192

13186 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 19 HOURS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SACRED HEART HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND
d. STREET ADDRESS: 1 J. AVE, POTOMAC PARK
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First EFFIE Middle VIOLA Last MESSMAN

4. DATE OF DEATH: Month DEC. Day 16 Year 19 58

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JAN. 2, 1889

9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): PENNA.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: SAMUEL HARDEN (DECEASED)

14. MOTHER'S MAIDEN NAME: SARAH MILLER (DECEASED)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: PATIENTS CHART — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH
420.1
DUE TO
(b): Hypertensive Cardio-Vascular Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12/15, 19 58, to 12/16, 19 58, that I last saw the deceased alive on 12/16, 19 58, and that death occurred at 1:10A. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Leo H. Ley Jr. M.D.
ADDRESS (Street, city or town, state): N. CENTRE ST., CUMBERLAND, MD.
DATE SIGNED: 12/18/58
PHYSICIAN'S NAME (Type): LEO H. LEY, JR., M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 12/18/58
22c. NAME OF CEMETERY OR CREMATORY: Sts. Peter & Paul Cemetery
22d. LOCATION (City, town, or county) (State): Cumberland Md.

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: John J. Hafer, Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: DEC 22 '58
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13193

Items 13,14 Film G236 12-15-58 et

13187 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 615 Maryland Avenue

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland, Maryland
d. STREET ADDRESS: 1 615 Maryland Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ELIZABETH — Middle SARAH — Last MILBURN

4. DATE OF DEATH: Month December — Day 6 — Year 19 58

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Feb. 22, 1884

9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Magnolia, West Virginia

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Clair R. Flora, Address: 321 Maryland Avenue Cumberland, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Uraemia	7 days
DUE TO (b)	Arteriosclerosis	5 yrs
DUE TO (c)	Cerebral Thrombosis	7 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

332x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan, 1956 to Dec 6, 1958, that I last saw the deceased alive on Dec. 4, 1958, and that death occurred at ____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Clay E. Durrett M.D.
ADDRESS (Street, city or town, state): Cumberland Md
DATE SIGNED: 12/6/58

PHYSICIAN'S NAME (Type): Clay E. Durrett M.D. 236 Virginia Avenue, Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Dec. 8, 1958
22c. NAME OF CEMETERY OR CREMATORY: Greenmount Cemetery
22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: John J. Hafer, Cumberland, Maryland

24a. REC'D BY REGISTRAR — DATE: DEC 10 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13194

13188 CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 220 Paca Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: Ignatius — Last: Mills

4. DATE OF DEATH: Month: 12 — Day: 24 — Year: 19 58

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug 27, 1875

9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Time Keeper

10b. KIND OF BUSINESS OR INDUSTRY: City of Cumb.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Patrick Mills

14. MOTHER'S MAIDEN NAME: Margaret Mc Cormick

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Chart
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 1 Year
DUE TO
420.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): generalized arteriosclerosis — 7 years
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. Month: Day: Year: 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12-2, 19 57 to 12-24, 19 58, that I last saw the deceased alive on 12-23, 19 58, and that death occurred at 1:30 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: L. Brings M.D.
ADDRESS (Street, city or town, state): 57 Green St. Cumberland Md
DATE SIGNED: 12-24-58

PHYSICIAN'S NAME (Type): Lewis Brings, M.D. — 57 Green Street Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Dec. 27, 1958
22c. NAME OF CEMETERY OR CREMATORY: St. Patricks
22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Charles L. George
ADDRESS: Cumberland, Maryland

24a. REC'D BY REGISTRAR DATE: DEC 29 58
24b. REGISTRAR'S SIGNATURE:

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13195

13189 #8- See Birth cert.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG Cumberland
c. LENGTH OF STAY IN 1b 7 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL WARWICK & MEMORIAL AVES.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 FROSTBURG
d. STREET ADDRESS /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
CINDAY	LOU	MINNICK	DECEMBER	20	1958

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH (August) SEPTEMBER 12	9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
FEMALE	WHITE			4				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		FROSTBURG, MARYLAND	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
CONRAD A. MINNICK	RUTH RAINER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
		MEMORIAL HOSPITAL CUMBERLAND, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH 24 hrs

DUE TO (b) Congenital Heart Disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 754.5

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Bilateral Pneumonia — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I attended the deceased from Dec 13, 1958, to Dec 20, 1958, that I last saw the deceased alive on Dec 20, 1958, and that death occurred at 9:45 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE J. Overton Himmelwright M.D. ADDRESS (Street, city or town, state) 133 Va ave, Cumberland, Md. DATE SIGNED 12/21/58

PHYSICIAN'S NAME (Type) DR. OVERTON HIMMELWRIGHT

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	12-23-58	Frostburg Memorial Park, Frostburg	Md.

23. FUNERAL DIRECTOR'S SIGNATURE Beulah H. Montemuro ADDRESS Hafer Funeral Home 23 E. Main, Frostburg, Md.

24a. REC'D BY REGISTRAR DATE DEC 29 '58

24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

206 15 1 XV 5

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13196

13190 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland,
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: W. Va. — b. COUNTY: Mineral
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ridgeley, 85 X-3
d. STREET ADDRESS: 15 Potomac Ave.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EDWARD — Middle DOUGLAS — Last MOON

4. DATE OF DEATH: Month Dec. — Day 17, — Year 1958

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 2, 1894

9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired oiler

10b. KIND OF BUSINESS OR INDUSTRY: Celanese Corp.

11. BIRTHPLACE (State or foreign country): Commerce Co. Texas

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: William W. Moon

14. MOTHER'S MAIDEN NAME: Martha Garner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No, (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-07-2143

17. INFORMANT: Mrs. Mary E. Moon — Address: 15 Potomac Ave., Ridgeley, W. Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute myocardial infarction. — INTERVAL BETWEEN ONSET AND DEATH: 2½ hours
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Hypertensive and arteriosclerotic cardiovascular — 10 years
DUE TO
(c) Generalized arteriosclerosis. — ???

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Acute myocardial infarction, anterior, August, 1956.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 1949, to 17 December 1958, that I last saw the deceased alive on 17 December, 1958, and that death occurred at 1:50 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W. Alfred Van Ormer M.D. — ADDRESS (Street, city or town, state): 122 So. Centre St., — DATE SIGNED: 12/18/58

PHYSICIAN'S NAME (Type): W. A. Van Ormer M. D. — Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12/20/58

22c. NAME OF CEMETERY OR CREMATORY: Frostburg Memorial Park

22d. LOCATION (City, town, or county) (State): Frostburg, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Charles L. George Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: DEC 22 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13191 — Reg. Dist. No. — 13197

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): 106 North Mechanic Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town): 02 Cumberland
d. STREET ADDRESS: 106 N. Mechanic Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Alexander — Middle: Moore — Last:
4. DATE OF DEATH: Month: December — Doy: 7 — Year: 1958

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Nov. 13, 1887
9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Janitor
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): St. James, Barbados. W. Indies
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 217-10-7712
17. INFORMANT: Address: Henry L. Davis, Cumberland, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CORONARY Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
420.1
DUE TO (b): CORONARY Sclerosis — —
Conditions, if ony, which gove rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

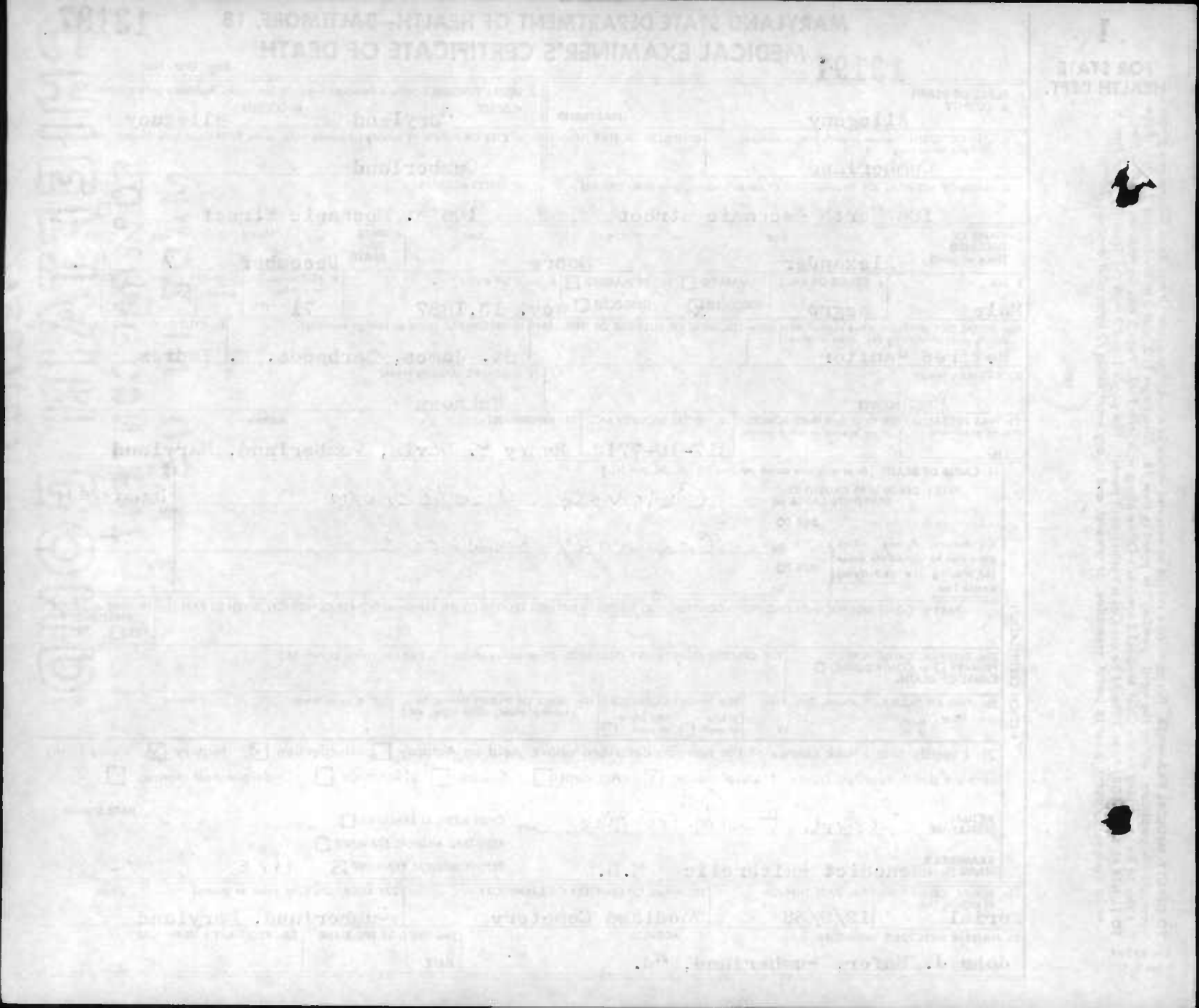
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my apinian death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Hamicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: Dec. 7, 1958.
EXAMINER'S NAME (Type): Benedict Skitarelic M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/9/58
22c. NAME OF CEMETERY OR CREMATORY: Woodlawn Cemetery
22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: John J. Hafer, Cumberland, Md.
24a. REC'D BY REGISTRAR DATE: DEC 10 '58
24b. REGISTRAR'S SIGNATURE: Clifton S. Evans



1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13234

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 1 FilmG237 1-12-59 et

13198

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Near Luke
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): ----

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland,
d. STREET ADDRESS: Trost Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM Middle JAMES Last MORGAN

4. DATE OF DEATH: Month December Day 5 Year 19 58

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 16, 1930

9. AGE (In years last birthday): 28 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Const. Wkr.

10b. KIND OF BUSINESS OR INDUSTRY: Tidewater-Hazelwood Const.

11. BIRTHPLACE (State or foreign country): Mt. Savage, Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas Morgan

14. MOTHER'S MAIDEN NAME: Nannie Scott

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Trost Avenue
Mrs. Jean Morgan Cumberland, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hemothorax — INTERVAL BETWEEN ONSET AND DEATH: 10 min.
9023
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Crushed Chest — 10 min.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Fell 58 feet from platform.

20c. TIME OF INJURY: Hour 9:30 a. m. p. m. Month, Day, Year Dec 5 1958

20d. INJURY OCCURRED: While at work ☒ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Factory

20f. (City or town) Luke, (County) Alleg. (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): Benedict Skiterelic MD.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: Dec. 5, 1958

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12/8/58

22c. NAME OF CEMETERY OR CREMATORY: St. Luke's Luth. Cem.

22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: John J. Hafer, Cumberland, Maryland

24a. REC'D BY REGISTRAR DATE: DEC 9 '58

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13192

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13199

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMD. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1. PLACE OF DEATH a. COUNTY: Allegany MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland c. LENGTH OF STAY IN 1b: DOA	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital	d. STREET ADDRESS: 412 S. Cedar Street e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print): First: William Middle: E Last: Mullenax	4. DATE OF DEATH: Month: Dec. Day: 4 Year: 1958
5. SEX: Male 6. COLOR OR RACE: White 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH: Aug. 24, ~~1958~~ 1922 9. AGE (In years last birthday): 36 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Welder 10b. KIND OF BUSINESS OR INDUSTRY: Ravena Ohio Arsenal 11. BIRTHPLACE (State or foreign country): Hightown, Virginia 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Hay H. Mullenax 14. MOTHER'S MAIDEN NAME: Mary Elizabeth Eye	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): yes WW II 16. SOCIAL SECURITY NO. 17. INFORMANT Address: Warren R. Mullenax, Rt. 1, Ridgeley, W.Va.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Hepatic Failure — Interval between onset and death: 6 Hrs.

581.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Fatty Infiltration of Liver — 24 Hrs.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cerebral edema, Marked

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

DATE SIGNED: Dec. 4, 1958

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial	22b. DATE THEREOF: Dec. 6, 1958	22c. NAME OF CEMETERY OR CREMATORY: Frostburg Memorial Park	22d. LOCATION (City, town, or county) (State): Frostburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR DATE: DEC 9 '58	24b. REGISTRAR'S SIGNATURE: Arthur S. Krause	

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13193

13200

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 1½ hrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 1212 Lafayette Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Margaret — Middle: M — Last: Neat
4. DATE OF DEATH: Month: Dec. — Day: 18 — Year: 1958
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov. 29, 1900
9. AGE (In years last birthday): 58 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): National, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William James Evans
14. MOTHER'S MAIDEN NAME: Emma Lancaster

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: 1212 Lafayette Avenue, Stanley E. Neat, Cumberland, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs.

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic disease
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY: Hour, a. m., p. m. — Month, Day, Year, 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held ~~[illegible]~~ Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: Dec. 18, 1958
EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/21/58
22c. NAME OF CEMETERY OR CREMATORY: Frostburg Memorial Park
22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: John J. Hafer, Cumberland, Md.
24a. REC'D BY REGISTRAR DATE: DEC 24 '58
24b. REGISTRAR'S SIGNATURE: Arthur L. Thomas

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG237 1-9-59 et

13201

13194 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY ALLEGANY
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XXXXXXXXXXXXCUMBERLAND
c. LENGTH OF STAY IN 1b 2 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION) MEMORIAL & WARWICK MEMORIAL HOSPITAL AVES.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND
b. COUNTY ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LITTLE ORLEANS
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First FREDERICK Middle Last O'BAKER

4. DATE OF DEATH Month DECEMBER Day 31 Year 1958

5. SEX MALE

6. COLOR OR RACE WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH NOVEMBER 16, 1879

9. AGE (In years last birthday) 79 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARETAKER

10b. KIND OF BUSINESS OR INDUSTRY SPORTS CLUB

11. BIRTHPLACE (State or foreign country) MARYLAND

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME HENRY, O' BAKER

14. MOTHER'S MAIDEN NAME MILLER, ELIZABETH

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
(a) IMMEDIATE CAUSE: Bilateral bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks
DUE TO
(b) Congestive heart failure — 2 weeks
DUE TO
(c)

4341
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4918

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Perforation of sigmoid - chicken bone - generalized peritonitis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov. 29, 1958, to Dec 31, 1958, that I last saw the deceased alive on Dec. 31, 1958, and that death occurred at 10:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Thomas F. Lewis M.D.
ADDRESS (Street, city or town, state) Algonquin Hotel, Cumberland, Md.
DATE SIGNED 1/1/59

PHYSICIAN'S NAME (Type) XXXXXXXXXXXX THOMAS F. LEWIS

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF 1/3/59

22c. NAME OF CEMETERY OR CREMATORY STS. PETER AND PAUL'S

22d. LOCATION (City, town, or county) (State) CUMBERLAND, MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS JOHN J. HAFER, CUMBERLAND, MARYLAND

24a. REC'D BY REGISTRAR DATE JAN 6 '59

24b. REGISTRAR'S SIGNATURE Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13202

13221 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westernport
c. LENGTH OF STAY IN 1b: 16 Yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 103 Philos Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 43 Westernport
d. STREET ADDRESS: 103 Philos Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First William — Middle Balangee — Last Orndorff

4. DATE OF DEATH: Month Dec. — Day 14 — Year 1958.

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 3, 1898
9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Minister
10b. KIND OF BUSINESS OR INDUSTRY: Church
11. BIRTHPLACE (State or foreign country): W.Va.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Thompson Orndorff
14. MOTHER'S MAIDEN NAME: Sarah E. Albright

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 214-05-6329
17. INFORMANT: Lola B. Orndorff — Address: Westernport, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Embolus — INTERVAL BETWEEN ONSET AND DEATH: 15 Min
DUE TO
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year, Hour, a. m., p. m., 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec. 14, 1958, to Dec. 14, 1958, that I last saw the deceased Dead alive on Dec. 14, 1958, and that death occurred at 1:55 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Paul R. Wilson M.D. — ADDRESS (Street, city or town, state): 111 Ashfield St Piedmont W.Va. — DATE SIGNED: 12-15-58

PHYSICIAN'S NAME (Type): Paul R. Wilson M.D

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/17/58
22c. NAME OF CEMETERY OR CREMATORY: Philos
22d. LOCATION (City, town, or county) (State): Westernport Md.

23. FUNERAL DIRECTOR'S SIGNATURE: E. L. Boal — ADDRESS: Westernport, Md.
24a. REC'D BY REGISTRAR DATE: DEC 17 '58
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13203

13195 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 1yr. 11mo. 13da.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Sylvan Retreat

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 43 Westernport
d. STREET ADDRESS: 146 Main St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles; Middle: F.; Last: Peters

4. DATE OF DEATH: Month: Dec.; Day: 13; Year: 19 58

5. SEX: M.

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 12, 1879

9. AGE (In years last birthday): 79 yrs.

IF UNDER 1 YEAR: Months; Days — IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant

10b. KIND OF BUSINESS OR INDUSTRY: Stationery store

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Ferdinand Peters

14. MOTHER'S MAIDEN NAME: Katherine Wack

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Mrs. Charles F. Peters—Westernport, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 053 Septicemia & Pyaemia — INTERVAL BETWEEN ONSET AND DEATH: 8 days.
DUE TO (b): 422.1 422 Chronic Myocarditis — ?
DUE TO (c): 450 General arteriosclerosis,

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 304 Senile psychosis & Obesity

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour; a. m. p. m.; Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec. 29, 1956, to Dec. 13th, 1958, that I last saw the deceased alive on Dec. 12, 1958, and that death occurred at 5:30a M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James E. McLean M.D. — ADDRESS (Street, city or town, state): 49 Greene St. — DATE SIGNED: 12/18/58

PHYSICIAN'S NAME (Type): James E. McLean, M.D. — 49 Greene St. Cumberland, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12/15/58

22c. NAME OF CEMETERY OR CREMATORY: Philos

22d. LOCATION (City, town, or county) (State): Westernport Md

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: E. J. Beal—Westernport, Md

24a. REC'D BY REGISTRAR — DATE: DEC 17 '58

24b. REGISTRAR'S SIGNATURE: Arthur L. Kness

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13196 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 13204

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 8 hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Corriganville
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Helen — Middle L. — Last Poland
4. DATE OF DEATH: Month Dec. — Day 3 — Year 1958
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. 31, 1907
9. AGE (In years last birthday): 51 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Corriganville, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Clites
14. MOTHER'S MAIDEN NAME: Alice Logsdon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT — Address: Lawrence Poland, Corriganville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Cardiac Tamponade, Intrapericardial Hemorrhage	2 hours
DUE TO (b)	Rupture of Aorta	2 hours
DUE TO (c)	Dissecting aneurysm of Aorta	2 hours

451X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY — Hour — a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED — While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.
DATE SIGNED: Dec. 4, 1958

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Dec. 7, 1958
22c. NAME OF CEMETERY OR CREMATORY: Porter Cemetery
22d. LOCATION (City, town, or county) (State): Hyndman, Bedford Co. Pa. Rd1

23. FUNERAL DIRECTOR'S SIGNATURE: Harvey H. Feigley
ADDRESS: Hyndman, Pa.
24a. REC'D BY REGISTRAR — DATE: DEC 8 '58
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

1 6

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13197 — 13205 Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 60 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Clement Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 26 Roberts Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Thornton — Middle: Ellsworth — Last: Poole
4. DATE OF DEATH: Month: Dec. — Day: 22 — Year: 19 58

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct. 14, 1878
9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer
10b. KIND OF BUSINESS OR INDUSTRY: Railroad
11. BIRTHPLACE (State or foreign country): Cherry Run, W. Va.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Poole
14. MOTHER'S MAIDEN NAME: Emma Ritten

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Margaret Poole, Cumberland, Md. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 30 in
420.1
DUE TO (b): Arteriosclerotic disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a).
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.
DATE SIGNED: Dec. 22, 1958

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-26-58
22c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: James F. Scarpelli, Cumberland, Md.
James F. Scarpelli
24a. REC'D BY REGISTRAR DATE: DEC 29 '58
24b. REGISTRAR'S SIGNATURE: Arthur S. Mann

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13206

13198 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 2 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL-WARWICK AND MEMORIAL AVE.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WILEY FORD W. Va. 85 x-3
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First SHARON Middle E. Last PORTER

4. DATE OF DEATH: Month DECEMBER Day 20 Year 1958

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: FEB. 26

9. AGE (In years last birthday): 6 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: ELMER A PORTER

14. MOTHER'S MAIDEN NAME: BERTHA WAGNER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: MEMORIAL HOSPITAL Address: CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 8 hr.
401.3
DUE TO (b): Acute Rheumatic Fever
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 490 X Bilateral Lobar Pneumonia — 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec 18, 1958, to Dec 20, 1958, that I last saw the deceased alive on Dec 20, 1958, and that death occurred at 1:29 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: H. H. Himmelwright M.D. — ADDRESS (Street, city or town, state): 133 Va ave, Cumberland, Md — DATE SIGNED: 12/24/58

PHYSICIAN'S NAME (Type): DR. OVERTON HIMMELWRIGHT

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/22/58
22c. NAME OF CEMETERY OR CREMATORY: Temple Cemetery Rose Hill Mausoleum
22d. LOCATION (City, town, or county) (State): Wellsburg Pa. Cumberland Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Louis Stein, Inc. — ADDRESS: Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: DEC 23 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13207

13199 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 3 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): × BALTIMORE PIKE
d. STREET ADDRESS: Rt. 3, Rocky Gap Rd. Cumberland
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First KENNEY Middle RAINES Last
4. DATE OF DEATH: Month DECEMBER Day 8 Year 1958
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: APRIL 1, 1871
9. AGE (In years last Birthday): 87 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Gen. Farming
11. BIRTHPLACE (State or foreign country): WEST VIRGINIA
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: MARTIN, RAINES
14. MOTHER'S MAIDEN NAME: Cynthia Hedrick

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: None
17. INFORMANT: MEMORIAL HOSPITAL — Address: CUMBERLAND, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia ? Hypertension C.V. Disease — INTERVAL BETWEEN ONSET AND DEATH: 1 month
443 ×
DUE TO (b): ? Renal Intermittent — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1958, to Dec. 8, 1958, that I last saw the deceased alive on Dec. 8, 1958, and that death occurred at 4:50 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: B. M. Schindler M.D. — ADDRESS (Street, city or town, state): 43 Greene Street Cumberland Md. — DATE SIGNED: 12/9/58

PHYSICIAN'S NAME (Type): DR. B. M. SCHINDLER M.D. 43 Greene Street, Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/11/58
22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park
22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: John J. Hafer, Cumberland, Maryland
24a. REC'D BY REGISTRAR DATE: DEC 11 '58
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13208

13200 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 2 HRS 50 MINS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WARNICK AND MEMORIAL HOSPITAL-MEMORIAL AVE.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND
d. STREET ADDRESS: P.O. BOX 92
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARTIN — Middle J. — Last REGAN

4. DATE OF DEATH: Month DECEMBER — Day 27 — Year 1958

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9-18-1887

9. AGE (In years last birthday): 71 yrs.

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired life insurance asst Supt & agent

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): PENNSYLVANIA

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: TIMOTHY REGAN

14. MOTHER'S MAIDEN NAME: JANE GREEN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 214-05-8566

17. INFORMANT: MEMORIAL HOSPITAL — Address: CUMBERLAND, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 3 hrs
420.1
DUE TO
(b): Arteriosclerotic Cardio Vascular Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour ___ o. m. p. m. Month ___ Day ___ Year 19___

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec, 1958, to Dec, 1958, that I last saw the deceased alive on Dec 27, 1958, and that death occurred at 5:50A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: O. H. Himmelwright M.D.
ADDRESS (Street, city or town, state): 133 Virginia Ave Cumberland, Md.
DATE SIGNED: Dec. 28, 1958
PHYSICIAN'S NAME (Type): DR. OVERTON HIMMELWRIGHT

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/29/58
22c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
22d. LOCATION (City, town, or county) (State): Cumberland Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Ruth E. Silcox
ADDRESS: Cumberland Maryland

24a. REC'D BY REGISTRAR DATE: DEC 31 '58
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film 237 12-30-58 et

13209

13222

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Son's home - Same as Item #2

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 22 Frostburg,
d. STREET ADDRESS: 1 S. Water Street, Extended
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Thomas — Middle: Wesley — Last: Richardson

4. DATE OF DEATH: Month: December — Day: 17th, — Year: 1958

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: Jan. 22nd, 1884

9. AGE (In years last birthday): 74 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret.-Coal Miner

10b. KIND OF BUSINESS OR INDUSTRY: Consol. Coal Co.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Thomas Richardson

14. MOTHER'S MAIDEN NAME: Nancy V. Miller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 213-09-6498

17. INFORMANT — Address: Charles Richardson, Frostburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic myocarditis. — INTERVAL BETWEEN ONSET AND DEATH: 10 years.
422.1
DUE TO
(b): Chronic bronchitis. — 12 years.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c): arterio-sclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)**

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May, 1948, to 12-17, 1958, that I last saw the deceased alive on 12-17, 1958, and that death occurred at 12:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: H. C. Diehl, M.D. — ADDRESS (Street, city or town, state): 39 W. Main St. — DATE SIGNED: 12/19/58

PHYSICIAN'S NAME (Type): H. C. DIEHL, M.D. — Frostburg, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12-20-58

22c. NAME OF CEMETERY OR CREMATORY: F'burg. Memorial Park

22d. LOCATION (City, town, or county) (State): Frostburg, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Joseph R. Durst, Frostburg, Md.

24a. REC'D BY REGISTRAR DATE: DEC 22 '58

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13210

13223 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Miners Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Frostburg, Rt. 1
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN — Middle W. — Lost RITCHIE

4. DATE OF DEATH: Month DEC. — Day 3, — Year 1958

5. SEX: Male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10-29-1898

9. AGE (In years last birthday): 60 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Custodian

10b. KIND OF BUSINESS OR INDUSTRY: Elementary school

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Ritchie

14. MOTHER'S MAIDEN NAME: Sarah Fisher

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 213-09-6502

17. INFORMANT — Address: Mrs. Nellie Ritchie, Frostburg, Md. Rt.1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 1 Month
DUE TO
422.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerosis / — 1 year
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Silicosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov 1, 19 58 to Dec 3, 19 58, that I last saw the deceased alive on Dec 2, 19 58, and that death occurred at 4:40 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W O McLane M.D.
ADDRESS (Street, city or town, state): E. Main St., Frostburg, Md.
DATE SIGNED: Dec 5 1958

PHYSICIAN'S NAME (Type): W. O. McLane, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12-5-58

22c. NAME OF CEMETERY OR CREMATORY: F'bg. Memorial Park

22d. LOCATION (City, town, or county) (State): Frostburg, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. R. Durst, — ADDRESS: Frostburg, Md.

24a. REC'D BY REGISTRAR DATE: DEC 8 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13235

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13211

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Flintstone
c. LENGTH OF STAY IN 1b: years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Flintstone

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Flintstone
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Agnes — Middle: E — Last: Roberts

4. DATE OF DEATH: Month: December — Day: 13 — Year: 19 58

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept. 25, 1869

9. AGE (In years last birthday): 89 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Artemas, Pennsylvania

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Wesley Collins

14. MOTHER'S MAIDEN NAME: Emma Tewell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Address: Mrs. H. C. Willison, Flintstone, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 30 min
422.1
DUE TO (b): Arteriosclerotic C V disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 904.0 Fracture of rt femur

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Fell at home,

20c. TIME OF INJURY: Hour: ~~a.m.~~ 4:30 p. m. — Month, Day, Year: Oct 30 1958

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) (County) (State): Flintstone, Alleg, Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: Dec. 13, 1958,

EXAMINER'S NAME (Type): Benedict Skitarelic M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12/16/58

22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park

22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: ADDRESS: John J. Hafer, Cumberland, Maryland

24a. REC'D BY REGISTRAR: DATE: DEC 22 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

1

DR. R/J.WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13212

13201 **CERTIFICATE OF DEATH**

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH a. COUNTY: ALLEGANY — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: MARYLAND b. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND — c. LENGTH OF STAY IN 1b: 2 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X FLINTSTONE
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: MEMORIAL HOSPITAL	d. STREET ADDRESS: / — e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
JAMES	HILLEARY	ROBERTS	DECEMBER	28	1958

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
MALE	WHITE		JAN. 13, 1885	73 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		MARYLAND	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
JERRY ROBERTS	NANNETTE NORRIS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
	192-03-3565	MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Chronic Nephritis — INTERVAL BETWEEN ONSET AND DEATH: 7 days

592 X

DUE TO (b): Uremia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): Hypertension Myocardial Disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12/26/58, 19____, to 12/28, 19 58, that I last saw the deceased alive on 12/28/58, 19____, and that death occurred at 11:00 AM from the causes and an the date stated abave.

ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state): Cumberland — DATE SIGNED: 12/29/58

PHYSICIAN'S NAME (Type): DR. R. J. WILLIAMS

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	12.31.58	Piney Plains	Little Orleans Allegany Md.

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Howard F. Hoye	Hancock md	JAN 6 '59	Arthur S. Krauss

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be recorded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
8M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13202

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13213
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 28 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: Smith Apts. Kelly Blvd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Theodore	M	Rose	Dec.	31	1958

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White		Dec. 13, 1888	70 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Police Officer	City Police	Lehe, Germany	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
XXXXX Martin R. Rose	Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No.	None	Sacred Heart Hosp. Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Pulmonary Embolism	3 Days
DUE TO (b)	Fracture of right Femur	27 Days
DUE TO (c)		

1 9040

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Slipped and Fell at a Friends house (Paca Street)

20c. TIME OF INJURY Hour	Month, Day, Year	20d. INJURY OCCURRED While at work ☐ Not while at work ☒	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
10:00 a. m. ☐ p. m. ☐	Dec. 3 1958		Home	Cumberland, Alleg. Md.

01

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED Jan. 1, 1959

EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	1/5/59	Rose Hill Cemetery	Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Charles L. George, Cumberland, Md.	JAN 6 '59	Arthur L. Krumpf

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13214

13203 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 9 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL WARWICK AND MEMORIAL AVES

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X KIFER
d. STREET ADDRESS: Kifer, Md.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ALTA — Middle LA VERNE — Last RYAN

4. DATE OF DEATH: Month DECEMBER — Day 30, — Year 1958

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: AUGUST 7, 1911

9. AGE (In years last birthday): 47 yrs. — IF UNDER 1 YEAR: Months 5 Days 23 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): MAGNOLIA, W. VA.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: LEWIS ~~MX~~ SHOCK

14. MOTHER'S MAIDEN NAME: MARY APPOLD

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: MEMORIAL HOSPITAL — Address: CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypertensive arteriosclerotic — INTERVAL BETWEEN ONSET AND DEATH: Since 9-25-58
447X
DUE TO
(b): vascular disease (uremia)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Left nephrectomy for staghorn type stone & functionless kidney — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9-25-, 1958, to 12-30-, 1958, that I last saw the deceased alive on 12-30-, 1958, and that death occurred at 1:15P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: W. F. Williams M.D. — ADDRESS (Street, city or town, state): Cumberland Md — DATE SIGNED: 12-31-58

PHYSICIAN'S NAME (Type): W. F. WILLIAMS

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 1-2-59 — 22c. NAME OF CEMETERY OR CREMATORY: CAMP HILL — 22d. LOCATION (City, town, or county) (State): PAW PAW, W. VA.

23. FUNERAL DIRECTOR'S SIGNATURE: PARKS FUNERAL HOME C E Johnson — ADDRESS: Berkeley Springs W. Va.

24a. REC'D BY REGISTRAR DATE: JAN 5 '59 — 24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13204 — 13215 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 3 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.O.A. Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Joseph — Middle Raymond — Last Schaidt
4. DATE OF DEATH: Month Dec. — Day 5 — Year 1958
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept. 5, 1958
9. AGE (In years last birthday): yrs.
IF UNDER 1 YEAR: Months 3 — Days — IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Cumberland, Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Joseph Robert Schaidt
14. MOTHER'S MAIDEN NAME: Merrie Jean Grose
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: none
17. INFORMANT Address: Mr. Joseph Schaidt, Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Asphyxiation	10-20 Min.
467.2 DUE TO (b)	Tracheal hemorrhage	10-20 Min.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour o. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.
DATE SIGNED: Dec. 5, 1958

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-8-58
22c. NAME OF CEMETERY OR CREMATORY: Oldtown Cemetery
22d. LOCATION (City, town, or county) (State): Oldtown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: James F. Scarpelli, Cumberland, Md.
24a. REC'D BY REGISTRAR DATE: DEC 8 '58
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

2060286 XV6

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13205 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 8,9 Film G237 1-5-59 et

13216

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 2/57

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital-DOA

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Penna. — b. COUNTY: West Moreland
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): West Newton
d. STREET ADDRESS: 203 Vine St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Joseph — Middle: Fisher — Last: Scholl

4. DATE OF DEATH: Month: Dec. — Day: 12 — Year: 1958

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 30, 1911 1912

9. AGE (In years last birthday): 47 46 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Supt.

10b. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (State or foreign country): West Newton, Penna.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Jasper T. Scholl

14. MOTHER'S MAIDEN NAME: Edith Hoy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 191-03-6997

17. INFORMANT: Mr. Earl Zimmerman — Address: West Newton, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Crushed Skull — INTERVAL BETWEEN ONSET AND DEATH: Sudden

825 X

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Automobile Accident

20c. TIME OF INJURY: Hour 12:45 a. m. p. m. — Month, Day, Year: Dec. 12 1958

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Street

20f. (City or town) (County) (State): 2½ M. west Lavalle, Alleg. Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: Dec. 12, 1958

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12/15/1958

22c. NAME OF CEMETERY OR CREMATORY: West Newton

22d. LOCATION (City, town, or county) (State): West Newton, Pa.

23. FUNERAL DIRECTOR'S SIGNATURE: Charles L. George — ADDRESS: Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: DEC 15 '58

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13217

13206 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 2 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WARWICK AND MEMORIAL HOSPITAL- MEMORIAL AVE.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X ELLERSLIE
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JESSE; Middle A.; Last SEE

4. DATE OF DEATH: Month DECEMBER; Day 6; Year 1958

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: MARCH 29

9. AGE (In years last birthday): 55 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Celanese Employee

10b. KIND OF BUSINESS OR INDUSTRY: Celanese

11. BIRTHPLACE (State or foreign country): PENNSYLVANIA

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: JOHN SEE

14. MOTHER'S MAIDEN NAME: SALLY HOSE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 214-07-1569

17. INFORMANT: MEMORIAL HOSPITAL — Address: CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Left Centricular Failure — INTERVAL BETWEEN ONSET AND DEATH: 40 hr.
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Coronary Arteriosclerosis — ?
DUE TO
(c) Myocardial Fibrosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Saddle Embolus (Iliacs)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m.; Month; Day; Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec. 4, 1958, to December 6, 1958, that I last saw the deceased alive on December 5, 1958, and that death occurred at 1:05 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Samuel Jacobson M.D.
ADDRESS (Street, city or town, state): 50 Pershing St. Cumberland, Maryland
DATE SIGNED: 12/6/58

PHYSICIAN'S NAME (Type): DR. S. M. JACOBSON

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Dec. 8, 1958
22c. NAME OF CEMETERY OR CREMATORY: Porter Cemetery
22d. LOCATION (City, town, or county) (State): Hyndman, Pa. RD#1 Bedford

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph A. Zeigler
ADDRESS: Hyndman, Pa.

24a. REC'D BY REGISTRAR DATE: DEC 11 '58
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13218

13207 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ellerslie
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Catherine Middle Elizabeth Last Simpkins

4. DATE OF DEATH: Month December Day 7 Year 1958

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: December 29, 1873

9. AGE (In years last birthday): 84 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Cove, Garrett Co., Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Kalbfleich

14. MOTHER'S MAIDEN NAME: Elizabeth Ringler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mr. Charles E. Simpkins, Address: Ellerslie, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 wk.
450.0
DUE TO
(b): Arteriosclerosis - Generalized
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m.

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12-7, 1958, to 12-7, 1958, that I last saw the deceased alive on 12-7, 1958, and that death occurred at 11:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: William P. James M.D. — ADDRESS (Street, city or town, state): 441 N. Centre St — DATE SIGNED: 12-8-58

PHYSICIAN'S NAME (Type): William P. James — Cumberland Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Dec. 10, 1958

22c. NAME OF CEMETERY OR CREMATORY: Porter Cemetery

22d. LOCATION (City, town, or county) (State): Hyndman, Pa. RD#1

23. FUNERAL DIRECTOR'S SIGNATURE: Harvey H. Zeigler — ADDRESS: Hyndman, Pa.

24a. REC'D BY REGISTRAR DATE: DEC 11 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13224

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13219

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Miners Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Lonaconing
d. STREET ADDRESS: State Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First DONNA Middle LEE Last SLOAN
4. DATE OF DEATH: Month Day Year: 12/22/1958
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 11th. 1942
9. AGE (In years last birthday): 16 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School Student, Valley High School
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Lonaconing, MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Sloan
14. MOTHER'S MAIDEN NAME: Marselle Allen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT Address: Mr. Charles Sloan, Lonaconing, Md. (FATHER)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): LACERATed Brain — INTERVAL BETWEEN ONSET AND DEATH: 1 hr span

825 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Fracture Left Skull — " "
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Automobile Accident - Highway RT 36
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year: 10:15 Dec 22 1958
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway
20f. (City or town) (County) (State): near Lonaconing Allegany Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: W O McLane M.D.
CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): W O McLANE MD and
DATE SIGNED: Dec 23 1958

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/25/1958
22c. NAME OF CEMETERY OR CREMATORY: Old Coney Cemetery
22d. LOCATION (City, town, or county) (State): Lonaconing, MD.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: GEORGE EICHHORN , Lonaconing, MD.
24a. REC'D BY REGISTRAR DATE: DEC 29 '58
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

1-

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13236 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13220

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1. PLACE OF DEATH
a. COUNTY: Allegany
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LONACONING
c. LENGTH OF STAY IN 1b: 58yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Detmold Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Lonaconing
d. STREET ADDRESS: Detmold Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GEORGE Middle Last STAFFORD
4. DATE OF DEATH: Month December Day 28 Year 1958
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7/20/1900 (XX/XX/1900)
9. AGE (In years last birthday): 58 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Lonaconing, MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Stafford
14. MOTHER'S MAIDEN NAME: Catherine Wilson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) War 1&2
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Elsie Maund, Monnesan, PA. (SISTER)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Wm McLane M.D.
EXAMINER'S NAME (Type): WM McLANE MD
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: Jan 3 - 1959

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1/4/1959
22c. NAME OF CEMETERY OR CREMATORY: Laurel Hill Cemetery
22d. LOCATION (City, town, or county) (State): Moscow, MD.

23. FUNERAL DIRECTOR'S SIGNATURE: GEORGE EICHHORN
ADDRESS: LONACONING, MD.
24a. REC'D BY REGISTRAR DATE: JAN 5 '59
24b. REGISTRAR'S SIGNATURE: Clarence L. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13221

13225 CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by [illegible] funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 54 E. College Avenue

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 22 Frostburg
d. STREET ADDRESS: 54 E. College Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MARY; Middle: ANN; Last: STARKEY

4. DATE OF DEATH: Month: 12; Day: 30; Year: 1958

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Nov. 15, 1882

9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homework

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Eckhart, Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William Harris

14. MOTHER'S MAIDEN NAME: Katherine Cross

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. Oliver Johnson, 54 E. College Ave., Address: Frostburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypertension
443X
DUE TO (b): Cardio Vascular Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 1 year several years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m.; Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec 30, 1958, to Dec 30, 1958, that I last saw the deceased alive on Dec 30, 1958, and that death occurred at 9:20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W D McLane M.D.
ADDRESS (Street, city or town, state): Frostburg
DATE SIGNED: Dec 31, 1958

PHYSICIAN'S NAME (Type): W D McLane M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1-2-1959
22c. NAME OF CEMETERY OR CREMATORY: Eckhart Cemetery
22d. LOCATION (City, town, or county) (State): Eckhart, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Ralph H. Montemurri
Hafer Funeral Home
23 E. Main, Frostburg, Md.

24a. REC'D BY REGISTRAR DATE: JAN 5 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13222

13208 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 6days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 16 N. Waverly Terrace
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Annie; Middle: ; Last: Swankhaus

4. DATE OF DEATH: Month: December; Day: 16; Year: 1958

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 2, 1877

9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Henry Swankhaus (Deceased)

14. MOTHER'S MAIDEN NAME: Katherine Swankhaus

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Patients Chart — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 331X Cerebral Vascular Accident, small, involving the Hypothalamus — INTERVAL BETWEEN ONSET AND DEATH: days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Cerebral and Generalized Arteriosclerosis — years
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Malnutrition and anemia secondary to Diagnosis #1.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from December 10, 1958, to December 16, 1958, that I last saw the deceased alive on December 16, 1958, and that death occurred at 6:55 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Wyand R. Doerner Jr M.D. — ADDRESS (Street, city or town, state): Algonquin Hotel, Cumberland, Md. — DATE SIGNED: 12-17-58

PHYSICIAN'S NAME (Type): Wyand Doerner Jr. M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Dec 19, 1958
22c. NAME OF CEMETERY OR CREMATORY: SS. Peter + Paul Cemetery
22d. LOCATION (City, town, or county) (State): Cumberland Allegany Md

23. FUNERAL DIRECTOR'S SIGNATURE: Louis Steinberg — ADDRESS: Cumberland Md

24a. REC'D BY REGISTRAR DATE: DEC 22 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13223

13237 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Eckhart
c. LENGTH OF STAY IN 1b: 25 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Eckhart
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GEORGE Middle E. Last TAYLOR

4. DATE OF DEATH: Month Dec. Day 3, Year 19 58

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10-4-1884

9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Maintenance

10b. KIND OF BUSINESS OR INDUSTRY: Coal Mines

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: supervisor Frederick Taylor

14. MOTHER'S MAIDEN NAME: Lucinda Rector

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 213-09-6608

17. INFORMANT Address: Mrs. Maude J. Taylor, Eckhart, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO
(b): Coronary Sclerosis — 1 year
DUE TO
(c):

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov 17, 19 58 to Dec 3, 19 58, that I last saw the deceased alive on Dec 1, 19 58, and that death occurred at 2:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W O McLane M.D.
ADDRESS (Street, city or town, state): E. Main St., Frostburg, Md.
DATE SIGNED: Dec 5 1958

PHYSICIAN'S NAME (Type): W. O. McLane, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-6-58
22c. NAME OF CEMETERY OR CREMATORY: F'bg. Memorial Park
22d. LOCATION (City, town, or county) (State): Frostburg, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: J. R. Durst, Frostburg, Md.

24a. REC'D BY REGISTRAR DATE: DEC 8 '58
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13224

13238 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Oldtown
c. LENGTH OF STAY IN 1b: 41 years
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Route 1,

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Oldtown
d. STREET ADDRESS: Route 1
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First ZELL — Middle L. — Last TETER

4. DATE OF DEATH: Month Dec. — Day 22, — Year 19 58

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: July 18,1876

9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Self

11. BIRTHPLACE (State or foreign country): W. Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jacob S. Teter

14. MOTHER'S MAIDEN NAME: Sadie Lantz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Mrs. Margaret Teter, Oldtown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocarditis Chronic — INTERVAL BETWEEN ONSET AND DEATH: 3-5 yr.
422.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerosis — I0*20 Yr
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 19__, to I2-I5-58, 19__, that I last saw the deceased alive on I2-I5-58, 19__, and that death occurred at I0 P.M, from the causes and on the date stated above.

ACTUAL SIGNATURE: J. T. Armstrong M.D. — ADDRESS (Street, city or town, state): Paw Paw, W. Va. — DATE SIGNED: I2-23-58

PHYSICIAN'S NAME (Type): J. T. Armstrong — Paw Paw, W. Va.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12/26/1958

22c. NAME OF CEMETERY OR CREMATORY: Oldtown Cemetery

22d. LOCATION (City, town, or county) (State): Oldtown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Byron Kight — ADDRESS: Cumberland, Md.

24a. REC'D BY REGISTRAR — DATE: DEC 29 '58

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deoth certificate be executed within 24 hours after deoth. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13225

13209 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 4 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL WARWICK & MEMORIAL AVENUES

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND
d. STREET ADDRESS: 216 SCHLEY STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: GRACE — Middle: E. — Last: TRIEBER

4. DATE OF DEATH: Month: DECEMBER — Day: 14, — Year: 19 58.

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JANUARY 31, 1880

9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: LOUIS SOYSTER

14. MOTHER'S MAIDEN NAME: CAROLINE MAGRUDER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — Address: MEMORIAL HOSPITAL - CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 4
DUE TO
443X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Hypertensive Cardio-Vascular
DUE TO
(c): Disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12/10, 1958, to 12/14, 1958, that I last saw the deceased alive on 12/14, 1958, and that death occurred at 2:53 P. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Leo H. Ley Jr M.D. — ADDRESS (Street, city or town, state): 456 N. Centre St. — DATE SIGNED: 12/16/58

PHYSICIAN'S NAME (Type): DR. LEO H. LEY — Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/17/58
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
22d. LOCATION (City, town, or county) (State): Cumberland Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Ruth E. Silcox Cumberland Maryland

24a. REC'D BY REGISTRAR DATE: DEC 19 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13226

13210

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 3 FilmG239 2-20-59 et

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 1 hour
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 1209 Lexington Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Carl — Middle: Lee — Last: Turner

4. DATE OF DEATH: Month: Dec. — Day: 16 — Year: 1958

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 5, 1901

9. AGE (In years last birthday): 57 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (State or foreign country): Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Turner

14. MOTHER'S MAIDEN NAME: Anna

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes
(If yes, give war or dates of service): War I

16. SOCIAL SECURITY NO.: 220-10-2430

17. INFORMANT — Address: Mrs. Carl L. Turner, Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.

420,1

DUE TO
(b): Coronary Sclerosis

DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Asthma

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour: o. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: Dec. 16, 1958

EXAMINER'S NAME (Type): Dr. Benedict Skitarelic

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-20-58
22c. NAME OF CEMETERY OR CREMATORY: Rest Lawn Gardens
22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: James F. Scarpelli, Cumberland, Md.

James F. Scarpelli

24a. REC'D BY REGISTRAR — DATE: DEC 22 '58

24b. REGISTRAR'S SIGNATURE: Arthur L. Kinsey

1

FOR STATE HEALTH DEPT.

13212

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13228

Film G 239 item 3 3/2/59 gg

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 55 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 828 Lafayette Avenue

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 828 Lafayette Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edward — Middle: Wilson — Last: Warnick

4. DATE OF DEATH: Month: Dec. — Day: 8 — Year: 1958

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Mar. 16, 1895

9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Brewing Co.

11. BIRTHPLACE (State or foreign country): Somerset, Pa.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: David L. Warnick

14. MOTHER'S MAIDEN NAME: Martha Ohler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes
(If yes, give war or dates of service): War I

16. SOCIAL SECURITY NO.: 214-05-4922

17. INFORMANT — Address: Mrs. Elizabeth Scott, Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
420.1
DUE TO
(b): Coronary Sclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: Dec. 8, 1958

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-11-58
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: James F. Scarpelli, Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: DEC 10 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13227

13211 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 3 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL WARWICK & MEMORIAL AVENUES

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: WEST VIRGINIA
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FORT ASHBY 85 x 3
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First NORMAN — Middle V. — Last WAGONER

4. DATE OF DEATH: Month DECEMBER — Day 28 — Year 19 58

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: NOVEMBER 13, 1881

9. AGE (In years last birthday): 77 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Self Emp.

11. BIRTHPLACE (State or foreign country): WEST VIRGINIA Springfield

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: NORMAN WAGONER

14. MOTHER'S MAIDEN NAME: Jane RICE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 723-09-0967A

17. INFORMANT: Address: MEMORIAL HOSPITAL - CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Hemorrhage with rt hemiplegia — INTERVAL BETWEEN ONSET AND DEATH: 25 Dec. 58

DUE TO (b): Hypertension and Arteriosclerotic

DUE TO (c): Pulmonary Disease — ?

331 X

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 25 Dec., 19 58 to 28 Dec., 19 58, that I last saw the deceased alive on 28 Dec., 19 58, and that death occurred at 4:40 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: W. Alfred Van Ormer M.D.

ADDRESS (Street, city or town, state): 177 S. Centre St. Cumberland, Md.

DATE SIGNED: 28 Dec 58

PHYSICIAN'S NAME (Type): DR. W. ALFRED VAN ORMER

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12-31-58

22c. NAME OF CEMETERY OR CREMATORY: Hill Cemetery

22d. LOCATION (City, town, or county) (State): Springfield, W.Va.

23. FUNERAL DIRECTOR'S SIGNATURE: James F. Scarpelli ADDRESS: Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: DEC 30 '58

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13223

13213 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 13 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 322 Holland St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Frank; Middle: Joseph; Last: Weisenmiller

4. DATE OF DEATH: Month: Dec. Day: 4 Year: 19 58

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1/29/92

9. AGE (In years last birthday): 66 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Steamfitter(retired)

10b. KIND OF BUSINESS OR INDUSTRY: Plumbing

11. BIRTHPLACE (State or foreign country): Maryland, Cumberland

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Jacob Weisenmiller (deceased)

14. MOTHER'S MAIDEN NAME: Eleanor Yupis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No, (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-05-7969

17. INFORMANT: Mrs. Margaret Weisenmiller — Address: 322 Holland St., Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Empyema — INTERVAL BETWEEN ONSET AND DEATH
518X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11/20, 19 58, to 12/4, 19 58, that I last saw the deceased alive on 12/4, 19 58, and that death occurred at 6:05 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Leo H. Ley Jr. M.D.
ADDRESS (Street, city or town, state): 456 N. Centre St., Cumberland, Md.
DATE SIGNED: 12/4/58

PHYSICIAN'S NAME (Type): Leo H. Ley, Jr., M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/6/58
22c. NAME OF CEMETERY OR CREMATORY: S. S. Peter & Paul's
22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Charles L. George Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: DEC 8 '58
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13214 CERTIFICATE OF DEATH

13230

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND,
c. LENGTH OF STAY IN 1b: 1 DAY
d. NAME OF HOSPITAL (If not in hospital, give street address or location) OR INSTITUTION: MEMORIAL HOSPITAL — WARWICK & MEMORIAL AVES.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND, MARYLAND
d. STREET ADDRESS: R.F.D.#4 Cumberland
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: DANIAL — Middle: S — Last: WHITACRE

4. DATE OF DEATH: Month: DECEMBER — Day: 10 — Year: 1958

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MAY 7, 1958

9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR Months: 7 Days: — IF UNDER 24 HRS. Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): CUMBERLAND, MARYLAND

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: WILLIAM WHITACRE

14. MOTHER'S MAIDEN NAME: MERRY COLE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: MEMORIAL HOSPITAL — Address: CUMBERLAND, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 2 hours

DUE TO (b): Malnutrition & Dehydration — 4 Months

DUE TO (c): Enlarged Heart (Congenital).

7545

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. / p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12-9-, 1958, to 12-10, 1958, that I last saw the deceased alive on 12-10, 1958, and that death occurred at 5:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: H W Eliason M.D. — ADDRESS (Street, city or town, state): 126 Union St. Cumberland Md — DATE SIGNED: 12/11/58

PHYSICIAN'S NAME (Type): DR. H. W. ELIASON

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12-12-58

22c. NAME OF CEMETERY OR CREMATORY: Davis Memorial Cem.

22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: James F. Scarpelli — ADDRESS: Cumberland, Md

Homer F. Scarpelli

2060233XV5

24a. REC'D BY REGISTRAR DATE: DEC 15 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by [redacted] funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13231

13215 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 24 Yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 223 Massachusetts Avenue

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 223 Massachusetts Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Margaret; Middle: A; Last: Whitson

4. DATE OF DEATH: Month: December; Day: 7; Year: 1958

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 19, 1870

9. AGE (In years last birthday): 88 yrs.

IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Lucas Appel

14. MOTHER'S MAIDEN NAME: Sarah Ann Miller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Roy Whitson — Address: Cumberland Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic cardia — INTERVAL BETWEEN ONSET AND DEATH: ?
422.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Vascular disease
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m.; Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec 3, 19 58, to Dec 7, 19 58, that I last saw the deceased alive on Dec. 5, 19 58, and that death occurred at 8:30 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: H. L. Williams M.D. — ADDRESS (Street, city or town, state): Cumberland Md — DATE SIGNED: 12/8/58

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/10/58
22c. NAME OF CEMETERY OR CREMATORY: Woodlawn Cemetery
22d. LOCATION (City, town, or county) (State): Baltimore Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Ruth E. Silcox — ADDRESS: Cumberland Maryland

24a. REC'D BY REGISTRAR DATE: DEC 10 '58

24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by [illegible] uneral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 [illegible]ld be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

DR. WHITWORTH **MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18** 13232

13216 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
c. LENGTH OF STAY IN 1b IDAY
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL, MEMORIAL AVENUE

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE ~~XXXXXXX~~ WEST VA. b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROMNEY 85x-3
d. STREET ADDRESS 431 N. FULTON ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First BABY Middle GIRL Last WOLFORD
4. DATE OF DEATH Month DECEMBER Day 22 Year 1958
5. SEX FEMALE
6. COLOR OR RACE WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 12-21-58
9. AGE (In years last birthday) yrs.
IF UNDER 1 YEAR Months Days 1 IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME WILLIAM WOLFORD
14. MOTHER'S MAIDEN NAME SUE E. BERRY
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address MEMORIAL HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Prematurity
DUE TO
776x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12-21, 1958, to 12-22, 1958, that I last saw the deceased alive on 12-22, 1958, and that death occurred at 10:25A M, from the causes and on the date stated above.

ACTUAL SIGNATURE Fuller P Whitworth M.D. ADDRESS (Street, city or town, state) Cumberland Md DATE SIGNED 27 Dec 58

PHYSICIAN'S NAME (Type) DR. FULLER P. WHITWORTH

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Dec. 23, 1958
22c. NAME OF CEMETERY OR CREMATORY Indian Mound Cem.
22d. LOCATION (City, town, or county) Romney (State) W. Va.

23. FUNERAL DIRECTOR'S SIGNATURE Keck Stoffer ADDRESS Romney W. Va.
24a. REC'D BY REGISTRAR DATE JAN 6 '59
24b. REGISTRAR'S SIGNATURE Arthur L Kuntz

20 69 12 2 V 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57